An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0189
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

This complaint relates to a claim under a health insurance policy.

The Complainant's Case

The Complainant incepted a health insurance policy with the Provider on **5 January 2017.**

The Complainant sets out her complaint, as follows:

> *"I visited my GP [on **6 January 2017**] for a repeat prescription of antihistamines, and also mentioned non-specific back pain that I had experienced. After suggesting I change my mattress, my GP agreed to refer me for an MRI (I was anxious as my brother had misaligned vertebrae, a serious issue, and my father has a long-standing disc herniation). This MRI [on **11 January 2017**] showed a very large tumour, which I had no knowledge of and was very shocked to discover. As a matter of urgency, I met [on **25 January 2017**] with and was treated by a neurosurgeon (operation [on **30 March 2017**]. [The Provider] refuse to cover this treatment, saying they consider it pre-existing, which I totally refuse. I did not expect this finding and went through considerable shock."*

In the Complainant's correspondence with this Office dated **31 October 2018**, the Complainant submits, among other things, as follows:

> *"It is my belief that* [the Provider] *have misinterpreted their own definition of pre-existing.*

> *No medical practitioner had diagnosed my symptoms or signs prior to my taking out health insurance. In fact,* [Dr. C. B.]*'s letter of* ***25 May 2018*** *confirms that my conditions were asymptomatic and are generally discovered coincidentally during investigations for other conditions."*

As a result, the Complainant seeks for the Provider to admit her health insurance claim *"and pay for the treatment I received for a condition, of which I had no prior knowledge when I purchased my health insurance policy."*

The Complainant's complaint is that the Provider wrongly or unfairly declined her health insurance claim and has misinterpreted its own definition of a pre-existing condition. The Complainant contends that she was unaware of any condition at the time of incepting the policy and should be covered for the subsequent claim.

The Provider's Case

The Provider contends that the Complainant's health insurance claim was in respect of a condition that pre-existed the commencement of her health insurance cover and that the Complainant does not meet the criteria to be covered for the claim.

The Complaint for Adjudication

The complaint for adjudication is that the Provider wrongly refused the Complainant's claim on the basis of a pre-existing condition.

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.

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A Preliminary Decision was issued to the parties on 15 April 2020, outlining my preliminary determination 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, I set out below my final determination.

On **5 January 2017** the Complainant incepted a health insurance policy with the Provider through the Provider's website. The Provider has furnished this Office with the relevant paragraphs which the Complainant would have had sight of when incepting the policy. Referred to as submissions. The last paragraph of submission 1 states as follow:

> *"By clicking "buy" you agree to enrol yourself, and your dependants (if applicable) as members of the schemes indicated."*

The Complainant bought the policy and was issued what the Provider describes as a welcome pack e-mail the following day **6 January 2017** which contained a link to the rules booklet within the member's area. These rules advised that waiting periods are applicable to any pre-existing conditions and the Provider places particular emphasis on Sections 2 and 9 of these. With Section 2 stating as follows:

> *"Pre-existing condition: 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 immediately preceding:*
>
> *a) The day you took out a Health insurance contract for the first time; or*
>
> *b) The day you took out a Healthy insurance contract again after your previous Health insurance contract had lapsed for 13 weeks or more.*
>
> *Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their decision is final".*

The Provider refers to Statutory Instrument 79 of 2015 – Health Insurance Act 1994 (Open Enrolment) Regulations 2015 which defines a pre-existing condition as follows:

> *'"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.'*

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Section 9a of the Provider's rules go on to advise that:

> *"We will not pay benefits for the following;*
>
> *Treatment which a person requires during any waiting period that may apply to the treatment under their scheme. All waiting periods commence on a person's membership start date or the date of the change to their policy/scheme..."*

The Complainant subsequently attended her G.P. the day after incepting her policy online, on **6 January 2017** '*for a repeat prescription of antihistamines, and also mentioned non-specific back pain that* [the Complainant] *had experienced*'.

The Complainant was referred for an MRI and Dexa scan. The Complainant underwent the MRI scan on **11 January 2017**, it is stated on the claim form to have been ongoing for two months, which would be prior to the inception of the policy the week prior. On **12 January 2017** the Complainant was referred to a Consultant Neurosurgeon for assessment concerning lumbar pain.

On **25 January 2017** the Complainant consulted with the Consultant Neurosurgeon, the subsequent clinic letter sent to the Complainant's G.P. stated:

> *'As you know she gives a history that since October she has been waking at night time with pain in the lower back. Since December she has had two or three episodes of severe pain in the left groin with pain radiating down the front of the left leg to the extent that she is unable to walk. "*

The Complainant subsequently was informed that she had a large paraverterbral tumour and the Consultant Neurosurgeon advised the tumour should be excised and that he would refer to both an Urologist and Vascular Surgeon for assessment prior to any surgery.

On **8 March 2017** the Complainant attended a Consultant Vascular and General Surgeon who documented in his clinic letter that the Complainant had a retro peritoneal mass causing back pain. In **March 2017** the Complainant was admitted to [named hospital] for excision of the [named tumour]. On **31 May 2017** the Consultant Neurosurgeon documented that the Complainant was recovering well and was nearly back to normal.

The Provider has not paid the Complainant's claim for the above medical episode contending that based on the information furnished the Provider's Medical Practice team concluded that the back pain which prompted the investigations that led to the diagnosis and the subsequent surgery was present and ongoing prior to the Complainant commencing cover with the Provider. Citing in particular the opinion of the Consultant Vascular and General Surgeon's finding that the Complainant had a retro peritoneal mass currently causing back pain.

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The issue in relation to pre-existing conditions was raised on phone calls with the Complainant and the Provider on **16 January 2017** when querying the cover for a consultation. On **26 January 2017**, the Complainant was advised that the Provider would not cover the scans she enquired about if the Consultant deemed the symptoms to be prior to joining. On **24 February 2017**, the Complainant was informed by the Provider that the Provider would not pay for the procedure queried if the symptoms were present prior to the date of inception.

The Complainant appealed the Provider's decision not to pay for the claim. The Provider's Medical Advisory Board assessed the claim, the information provided for review was evaluated by an Orthopaedic Surgeon who determined that:

> *"[named tumour] is a rare tumour which is benign and arises from autonomic nerve fibers.*
>
> *When they grow they can be substantially large och [sic] the growth of the tumour by itself [sic] is asymptomatic but depending on the location of the tumour, it decides the presenting symptoms, as pressure symptoms.*
>
> *In this case the tumour was assumed to arise from L3 nerve root on the left side and extends from L1 to L5.*
>
> *Based on this location the tumour could give symptoms as back pain and radiating pain along L3 on the left side. The L3 covers from the groin to the anterior side of the thigh.*
>
> *In this case the patient's symptom started in October 2016 and in December 2016 she had back pain with radiating pain on the front of the left leg. These symptoms in relation to the location of the [named tumour] indicate that the patient's symptoms are related to the tumour.*
>
> *Therefore, the earliest date on which the patient presented with symptoms of [named tumour] is in October 2016."*

Based on the recommendations of the Provider's medical practice team at first instance and the international medical advisory board the Provider was unable to consider the claim for benefit in line with the pre-existing waiting period.

The Provider contends that based on the information the signs and symptoms which led to the Complainant's diagnosis existed in the period prior to the Complainant incepting the policy on **5 January 2017**.

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It is important to note that a pre-existing condition as defined by the legislature in the statutory instrument cited above is not dependant on when the Complainant attended her G.P. first but is dependent on when "*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 is clear that the Complainant had the symptoms in October of 2016 and December of 2016 where the symptoms in December where so debilitating in nature that the Complainant could not walk.

I accept that the Provider has not misinterpreted their own definition of "*pre-existing*" and also accept that the Provider was entitled to refuse to pay the claim on the basis of the medical evidence of the Complainant complaining of symptoms occurring prior to the inception of the policy. I further accept that the Complainant may not have known what was causing these symptoms specifically until seeking medical advice the day after the inception of the policy, however, this does not have any effect on the fact that the symptoms were present and pre-existing at the inception of the policy.

Accordingly, while I accept that the Complainant finds herself in a very difficult situation, I do not uphold this complaint as the Provider has acted within the terms and conditions of the policy.

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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

7 May 2020

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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.