Decision Ref:	2020-0259
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	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

This complaint concerns a health insurance policy. The Complainant made a claim under the policy in the amount of €8,858.00 for the cost of hospitalisation and treatment for his son, L, [age redacted] on admission to hospital, in the period from **[date redacted] April 2018** to **[date redacted] April 2018.**

The complaint is that the Provider has wrongfully repudiated the Complainant's claim for his son L's treatment under the policy. The Provider's position is that cover was declined on the basis that L's treatment was in respect of a previously existing condition, which was subject to a waiting period, not fully served at the time of the treatment.

The Complainant's Case

The Complainant is unhappy with the Provider's declinature of his claim made under the policy. He submits that L is being treated unfairly due to being *"born with a previously undiagnosed congenital birth defect condition"*. The Complainant maintains that it was never *"conclusively proven that the symptoms referred to were 100% caused by L's diagnosis of [named lung disease]"* and that the symptoms could have been related to his background of [illness redacted] and associated related issues.

The Complainant further states that L had not previously shown symptoms of the condition though it has been present since birth. The Complainant states that L's paediatric respiratory consultant is also of the view that [named lung condition] *"has been present from birth and is a congenital birth defect condition"*.

The Provider's Case

The Provider submits that the policy was incepted on **25 October 2017** with no previous private medical insurance noted. As this was L's first period of medical insurance cover, this cover is subject to a 5-year waiting period for any pre-existing conditions.

The Provider states that this rule was communicated to the Complainant upon receiving a quotation from the Provider on **19 October 2017** and again when incepting the policy on **25 October 2017**.

The Provider is satisfied that the Complainant's claim was declined in accordance with the terms and conditions of the health insurance policy, based on the information available at the time of assessing the claim. The Provider states that the claim was declined as the evidence furnished with the claim indicated that the symptom which prompted his son L's admission to hospital was present prior to him being covered by the policy (such cover commencing in **October 2017**) and that

> *" in line with the pre-existing condition waiting period [the] claim was not eligible for benefit."*

The Provider contends that it will be *"unable to consider further treatment related to the above symptoms for benefit until the pre-existing waiting period has been served"*, and has advised that this waiting period will be served in **October 2022**.

Evidence

- **Provider General Rules Policy Booklet as at October 2017 – Policy Definitions**

"Pre-existing condition" - Section 2 page 5

> *"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 Health Insurance Contract again after your previous Health Insurance Contract had lapsed for 13 weeks or more."*

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Waiting periods

The following waiting periods will apply if you are aged:	**Under 55 years of age**	**55-59 years of age**	**60-64 years of age**	**Over 65 years of age**
How long before you can make a claim for accident or injury?	Immediately for all age groups			
How long before you can make a claim for any new disease, illness or injury which began or the symptoms of which began after membership started?	26 weeks for all age groups			
How long before you can claim for any disease, illness or injury which began or the symptoms of which began before membership started?	5 years for all age groups			
How long before you can claim benefit for maternity cover?	I year	Not applicable		

<u>What is not covered under the scheme - Section 9, page 11</u>

a) "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 pre-existing condition waiting period is:

- *"the first five years of membership".*

- **<u>Claim Form</u>**

[Details illness redacted]

a)"Date you first saw patient with symptoms – 3 April 2018
Duration of Symptoms prior to this – 1 Day, 1 month and 2 years"

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b) Noted previous condition of [illness redacted]

c) Treatment

[details of treatment redacted]

d) Primary Diagnosis

[details fo primary diagnosis redacted]

- **Consultant Post Admission Letter from L's Consultant, dated 30 April 2018**

"…. child was admitted on 03/04/2018 to Hospital suffering from chronic cough productive with green sputum for two years".

"…. has a background of [illness redacted]"

"The procedure was uneventful and [L] was diagnosed with [named lung disease]"

"[L] symptomatically improved following this"

- **Final Response Letter from the Provider to the Complainant dated 30 April 2019**

*"…. the information provided with your claim indicated that the symptom of chronic cough productive with green sputum for two years, which prompted [L's] admission, was present prior to [L] commencing cover with the Provider on **25 October 2017**".*

"…. when establishing the onset date, it is important to note that it is the date on which the symptoms occur and not the diagnosis date which determines if a condition is pre-existing"

"A pre-existing condition is defined as an *ailment, illness or condition existed at any time in the period of six 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 Health 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."*

"…. on acquiring cover with the Provider [L] was subject to a 5-year pre-existing condition waiting period for pre-existing conditions and any signs or symptoms of that condition that existed prior to joining."

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- **Email from the Complainant to the FSPO dated 21 January 2020**

"Unfortunately, Provider's terms and conditions do not in my opinion clearly address the situation of un-diagnosed congenital issues as was the case with [L].
…

My reading of the Provider's five-year exclusion clause is that it is applicable to acquired illnesses and possibly pre-diagnosed congenital issues only. [Named lung disease] is not an acquired illness and in [L's] case was never diagnosed although present from birth.
…

Accordingly I do not feel that the Provider's terms and conditions relating to the five year exclusion period adequately and clearly state they apply to previous un-diagnosed or misdiagnosed congenital issues, especially [named lung disease] the symptoms of which can manifest at various levels of severity at any stage from birth.

…. I feel that the Provider's terms and conditions are discriminatory towards people, especially children who have un-diagnosed congenital health problems."

- **Provider's formal response to FSPO dated 24 March 2020**

> *"Our medical advisors determine whether a condition is pre-existing or not solely based on the medical information available. The age of the member is irrelevant.*
> *A pre-existing condition is based on signs and symptoms and not diagnosis and [the Provider] are satisfied based on the available medical information that the signs and symptoms of this condition existed before [L's] joining on **25 October 2017**.*
> *…*
>
> *"The claim form, which was signed, by the Complainant and the treating doctor also advises the Provider [duration of symptoms prior to this 1 day 1 month 2 years]".*
>
> *We understand the Complainant wants [the Provider] to:*
>
> 1. *Pay the claim for [L's] hospital treatment;*
> 2. *Not subject [L's] condition to the five-year waiting period under the policy.*
>
> *…*
>
> *…. [the Provider] cannot agree to the above as the pre-existing waiting period for new joiners to private medical insurance applies to all members and across all insurers and [the Provider] must treat all members the same. As per the Health Insurance Authority – New Customer Waiting Periods"*

- **Telephone Calls**

Recordings of telephone calls between the Complainants and the Provider were submitted by the Provider as part of its formal response to this Office.

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The waiting period rule was advised to the Complainant upon receiving a quotation by telephone from the Provider on **19 October 2017**, wherein the Provider stated:

> *"…. any existing or pre-existing conditions you're suffering the signs or symptoms of either now or six months prior to the date of prior to taking out the Health Insurance cover they won't be covered for the first 5 years under the Health Insurance Act."*

In a subsequent phone call with the Provider, on **25 October 2017**, the Complainant proceeded to accept the Health Insurance Policy following a detailed discussion during which the Complainant asked for clarity on a number of the terms and conditions in relation to the policy and questioned the proposed quotations. This call lasted 19 minutes 11 seconds during which the waiting period rule was again explained to the Complainant.

> Provider: *"So you are aware that they will have a 5 year waiting period"*
>
> Complainant: *"…. I do, would you just go through that again, if you don't' mind. I know there is some waiting period."*

The Complaint for Adjudication

The complaint is that the Provider has wrongfully repudiated the Complainant's claim for the cost of his son L's treatment under the policy, on the basis that the treatment was for a pre-existing condition, cover for which was subject to a waiting period, not fully served at the time of the treatment.

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 **9 July 2020**, 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.

Analysis

The relationship between the parties is governed by the terms of the agreement between them which is contained in the General Rules Policy Booklet. The Complainant's policy was incepted on **October 2017** and the Provider furnished the Complainant with a Welcome Pack that included a copy of the general rules booklet.

In determining this complaint, it is necessary to have regard to the rules contained in the general rules brochure, the terms of which govern the Complainant's policy cover. Specific regard must be had to the rules in relation to the waiting period for pre-existing conditions, which were made available to the Complainant when his policy was incepted.

These terms set out that all waiting periods commence on a person's membership start date, or the date of change to their policy/scheme. I also note the stipulation that the pre-existing condition waiting period, is the first five years of membership.

I note that the Complainant is unhappy with the Provider's declinature of his claim under the policy, his submission being that that L is being treated unfairly due to having been

> *"born with a previously undiagnosed congenital birth defect condition."*

I note however, that the decision of the Provider to decline cover in respect the Complainant's treatment, does not arise because of any failure by the Provider to accept that the condition was a previously undiagnosed congenital birth defect condition. Rather, the Provider's decision is based on the definition of a "*pre-existing condition*", within the general rules of the policy terms and conditions, and the fact that pre-existing conditions are subject to a 5 year waiting period before cover becomes available.
In this instance, the Complainant's son L did not hold medical cover under the policy for a period of 5 years, before he required treatment for *[named lung disease]*. Consequently, the policy provides no cover for the cost of the treatment undergone, if the treatment undergone by L. was for a "*pre-existing condition*" within the meaning of the policy.

These policy sets out the definition of a pre-existing condition, stating that it is an **ailment/illness/condition, where, on the basis of medical advice, the signs/symptoms of the ailment/illness/condition existed at any time in the six month period immediately preceding the date that cover commenced.**

I note that L. was admitted to hospital for investigations on **3 April 2018** as he had a chronic cough; he had previous diagnoses of [illness redacted]. L. underwent CXR, CT chest, blood

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tests, microbiological tests and bronchoscopy. He was given IV antibiotic course and physiotherapy and inhaled steroid. He was discharged on **13 April 2018** with diagnosis of *[named lung disease].* This is noted on the Claim Form signed by the Complainant on **4 April 2018** and sometime later by the treating Consultant on the **17 April 2018.**

The Claim Form signed by the Complainant and the treating doctor, confirms that symptoms had been present for more than 2 years, ie. from **2016**. In those circumstances, I am satisfied that the Provider was entitled to form the opinion that such symptoms existed in the six month period immediately preceding the date when cover commenced in **October 2017**, and consequently, that the treatment undergone by L. in **April 2018**, was for a pre-existing condition within the meaning of the policy. It is not necessary for a diagnosis to be present for such a condition, or a title to be put on an illness; rather it is the presence of symptoms which is relevant for the said definition of a *"pre-existing condition".*

I accept the Complainant's submission that the paediatric respiratory consultant is also of the view that [named lung condition] *"has been present from birth and is a congenital birth defect condition"* and remained undetected until **2018.** However, in circumstances where the symptoms were present in the 6 months prior to commencing the Health Insurance Policy, the definition of a pre-existing condition was met. I also accept that the Provider advised the Complainant on a number of occasions about the waiting period for pre-existing conditions, both in writing (through the policy document, terms and conditions) and during two telephone calls in **October 2017**. I would note that during these calls, the Providers' staff took time to explain in detail the *'waiting period rule'* and made every effort to assist the Complainant's understanding of how it would apply to those insured under his policy.

The Complainant maintains that it was never *"conclusively proven that the symptoms referred to were 100% caused by L's diagnosis of [named lung disease]"* and he believes that the symptoms could have been related to his background of [illness redacted] and associated related issues. This Claim Form indeed notes that there had been a previous history of these issues, which also appear to have been pre-existing conditions, within the meaning of the policy cover. However, L's condition improved following the treatment for [named lung disease], as stated by his Consultant in his letter dated **3 April 2018**:

> "*The procedure was uneventful and [L] was diagnosed with [named lung disease]… [L] symptomatically improved following this".*

I appreciate that the declinature of the claim for L's treatment has been disappointing to the Complainant. 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 son's condition in respect of which he received medical treatment in April 2018, was a pre-existing condition, within the meaning of the policy cover, and that it was entitled to decline cover for the claim in the circumstances.

Accordingly, I do not find that there are any grounds upon which it would be appropriate or reasonable to uphold the Complainant's complaint.

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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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 July 2020

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.