An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0280
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complaint concerns a health insurance policy held by the Complainants.

The Complainants' Case

The first Complainant was admitted to a private hospital and underwent surgery for major spinal injury on the **6 December 2018**. The Complainants state that they were informed that their health insurance claim was rejected "*on the basis that the symptoms were present prior to my increasing on **8th February 2017***", as there was a two-year waiting period on the Complainants' policy before pre-existing conditions would be covered.

The Complainants attest that they were advised that they were covered for the surgery, as they "*had a telephone conversation with an agent in the week starting **23rd July 2018***" where they were "*assured that I was covered as onset of symptoms was after our increased benefits in February 2017*".

The Complainants stated that they received copies of the correspondence between their medical practitioners alongside the Final Response Letter from their Provider. In these documents, the First Complainant contends that the "*correspondence between these specialists contains significant inaccuracies, in particular my age being five years older and duration of symptoms as 3-4 years*". The Complainants state that "*this discrepancy was then repeated and perpetuated in subsequent correspondence*".

In their submissions, the Complainants state that the symptoms of the First Complainant's illness were instead only present for six months prior to the diagnosis, and that the long-term condition referred to in the correspondence was unrelated to the diagnosis that the First Complainant received in February 2018.

In relation to this, the First Complainant's surgeon wrote to the Provider on 16 April 2019 stating that these two diagnosis "*are not one and the same thing*" and that "*this patient does not have a pre-existing condition.*"

The Provider's Case

The Provider submits that "*this claim was declined as the information provided with your claim indicated that the symptoms … were present prior to you increasing your benefits to include cover for the* [Private Hospital] *on* ***08 February 2017***".

As the Complainants "*were serving a two-year upgrade waiting period*", the claim was assessed on the Complainants' previous plan, which did not include cover for the private hospital.

The Provider has submitted a timeline of events leading up to the surgery taking place. The Provider also addressed the Complainants' appeal to its external Medical Advisory Board, which determined that the "*current presentation was a 3-4 year history of* [symptoms]", and noted that the diagnosed symptoms had "*likely started 16 years ago with a prolonged period of stabilisation with subsequent recurrence and deterioration of symptoms from 3-4 years ago*".

The Provider further submits that

> "*they were also advised that they were still serving their five-year waiting for pre-existing conditions as they only had Irish health insurance since* ***8/02/15*** *and therefore still had three years of this left to serve. All calls are included in the Schedule of Evidence".*

The Complaint for Adjudication

The complaint is that the Provider wrongfully rejected the Complainants' claim in reliance on medical notes containing inaccurate information.

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.

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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 **28 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 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 Provider has declined the Complainants' claim, under their health insurance policy for the costs incurred for a stay in [Private Hospital] between 6/12/18 and the 12/12/18, on the basis that

> "*the Complainant was only with us since **8/02/17** and would have been subject to waiting periods, previous private medical insurance details were sought. From the **08/02/15** to **08/02/17** the Complainant was a member of* [a different Provider] *and so had no access to the* [Private Hospital] *as* she *does on* her *current plan with* [the Provider], [Product Name] *and so is subject to a two year upgrade rule for any pre-existing conditions for this hospital*". This rule "*was advised on the joining call on the **7/02/17**. This was also outlined in the rules booklet sent to the member as part of her Welcome pack on the 8/02/17*".

The documentary evidence submitted shows that on the **8 February 2017** the Complainants were issued with their policy documentation, including their Membership Certificate, Table of Cover, General Rules Booklet and Terms of Business.

The Provider declined the Complainants' claim on **15 April 2019**. In its letter of declinature, the Provider informed the First Complainant as follows:

> "*This claim was declined as the information provided with your claim indicated that the symptoms, which prompted your referral to* [the First consultant] *and your subsequent surgery under the care of* [the second consultant], *were present prior to you increasing your benefits to include cover for the* [Private Hospital] *on 08 February 2017.*

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Therefore, as you were serving a two-year upgrade waiting period your claim was assessed in accordance with your previous scheme, [with the previous provider]. *The* [Plan Name] *does not provide cover for the* [Private Hospital] *therefore your claim was not eligible for benefit.*

Please take into account, 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".

Chronology of Events

- On 8 **February 2015** the Complainants obtained health insurance from a former health insurance provider.

- On **7 February 2017** the Complainants called the Provider to start a new health insurance policy. The Provider representative explained the difference in cover between the former provider and itself. The Provider representative informed the Complainants of the waiting periods for any pre-existing conditions.

- On **13 February 2018** the First Complainant was referred to [the First Consultant] Neurologist and the referral letter noted the following "*in last 6 months concerns re* [First Complainant] *balance, gait "dragging her leg", longstanding issues with cervical disc disease."*

- On **17 April 2018** the First Complainant consulted with the [the First Consultant] who in the follow up letter to the First Complainant's GP, stated as follows

  "[First Complainant] *is a [age redacted] right-handed woman who has noticed stiffening and clumsiness of the right leg over the last 3 to 4 years gradually progressive. There is no sensory loss. There is no pain, low back pain or neurogenic claudication. There is no sciatica. There are no bowel or bladder symptoms. She may get an electric shock down her hands and legs when her husband stops the car suddenly but not with neck flexion or extension. She can still walk down the length of the pier but may have to link with her husband due to a circumducting gait.*"

- On **17 April 2018** the First Consultant wrote to the Second Consultant

  "*I would appreciate if you could review this [age redacted] woman with a cervical myelopathy originally diagnosed in 2002 in [location redacted] with some High signal and disc at C4/5 although treated conservatively with stable scans in 2006. Over the last 3 to 4 years the right leg has been dragging and on examination she has an asymmetric myelopathy with motor neurone signs on the right leg. She has prior lumbar disc disease but not active at present. She also has a history of ….*"

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- On **19 June 2018** the First Consultant wrote to the Second Consultant requesting a referral and noted

  "*I would appreciate if you could see this [age redacted] woman, who has symptomatic cervical stenosis with an asymmetric myelopathy affecting the right leg over the last few years*".

- On **16 July 2018** the Second Consultant wrote to the First Consultant who noted the following

  "*she developed electric shock-like symptoms in her arms and tingling in her arms in 2002. At this stage she was diagnosed with three-level cervical stenosis. She has managed conservatively and her symptoms seemed to have improved after this….*

  Over the last couple of years, she has noticed gait abnormality and she is worried this is progressive. She notices this more when she is tired. She feels like she is dragging her legs. She basically feels like she has a "wobbly" right leg. Her hand function is a little clumsy, but this is not getting progressively worse."

- On **18 July 2018** the Complainants contacted the Provider enquiring about cover for a procedure at the private hospital. The Provider representative informed the Complainants that "*this is provided the condition is a new condition since feb last yr so the consultant will send all that info in to us with the claim"*.

- On **28 August 2018** the Complainants called the Provider representative enquiring about cover for a procedure in the [Private Hospital]. The Provider representative informed the Complainants that

  "*if any medical reports come in and advise its pre-existing that's when difficulties will occur so be very black and white with the* [Consultant] *before the procedure have a word with him get clarity for your own piece of mind as well."*

- On **21 September 2018** a representative of [Private Hospital] called the Provider. The Private Hospital representative asked the Provider representative "*so she would have a pre existing waiting period on that would she?"* to which the Provider representative replied "*ya so if there's a lower level of cover there's a 2yr upgrade rule if it's a pre existing condition before she upgraded."*

- In the Operative Report dated **December 2018** which followed the First Complainant's surgery, the Second Consultant noted :

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> "[First Complainant] *was referred to me 5 months ago from a neurologist with a diagnosis of cervical myelopathy. She had an eighteen month history of a clumsy, weak right lower limb and imaging revealed stenosis between C3 and C7. Surgical decompression was offered which she accepted and informed consent was obtained.*"

- On **16 April 2019** the Second Consultant wrote to the Provider advising that

> "*you have rejected her claim on the basis that she had a pre-existing medical condition. She was diagnosed with cervical stenosis in the past, but she was recently diagnosed with cervical myelopathy. Cervical stenosis and cervical myelopathy are not the same thing.*"

- On **17 April 2019** the First Complainant wrote to the First Consultant

> "*to seek clarification regarding the report you sent to my GP… the referral letter clearly states the duration of my symptoms as six months, but you have stated they were for a duration of 3-4 years. You have also incidentally state my age as five years older than I am.*"

- On **17 April 2019** the First Complainant wrote to the Second Consultant and stated that

> "*the chronology of my new right leg symptoms have been stated incorrectly and has been repeated and duplicated in further correspondence between you and* [the First Consultant]*. However in your Operative report, dated 6th December 2018, you state more accurately that I have an eighteen month history of right lower limb symptoms, which would make earlies onset June 2017.*"

<u>Policy Terms and Conditions</u>

The operation of the Complainants' health insurance policy is set out within the terms and conditions of the contract, which are contained in the general rules policy booklet. I note that it is a term of the Complainants' contract (at page 12 of the General Rules Policy Booklet) that the Provider will not pay benefits for

> *Treatment which a person requires during any waiting period that may apply to the treatment under their scheme*".

I also note that certain specific exclusions from cover are set out at page 13 of the General Rules Policy Booklet, including the following:

- *the initial waiting period – this applies to any treatment that a person may require*
- *the pre-existing condition waiting period – this only applies to treatment which a person requires for a pre-existing condition*

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- *the maternity waiting period – this only applies to treatment that a person requires for pregnancy or childbirth*
- *the additional cover waiting period – following a change to a person's level of cover/benefits, this waiting period applies to additional cover/benefits for any pre-existing conditions.*
- *the infertility waiting period, fertility preservation and First Steps Fertility Benefit waiting period – these apply to fertility treatment which a person may be eligible for under their scheme.*

The initial waiting period is

- *the first 26 weeks of membership*

The pre-existing condition waiting period is

- *the first five years of membership*

The maternity waiting period applies to

- *the maternity in-patient and home birth benefits in the Benefit Table and applies during the first 52 weeks of membership.*

The additional cover waiting period is

- *the first 2 years following the change*.

I note that the policy sets out the initial waiting period which applies in the case of an upgraded level of cover, where the applicable waiting period is two years.

The term "**pre-existing condition**" is defined at page 5 of the General Rules Policy Handbook 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 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: or*
> *c) The day you changed your scheme and gained additional cover/benefits.*
>
> ***Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final***".

The policy sets out the pre-existing condition waiting period, which applies as outlined above. It is not disputed that the Complainants had a health insurance policy with their previous provider from 08/02/15 to 08/02/17. It seems that the Complainants had no access to [Private Hospital] up to that time. In these circumstances, in accordance with the terms and conditions of the Complainants' policy with the Provider, the Complainants were subject to the waiting period of two years, as defined above, regarding their upgrade in cover.

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The Provider has indicated in its submissions to this office that the Complainants' claim was declined because the stay in the private hospital took place before the Complainants' waiting period had been fully served, and was not therefore covered.

The Provider is entitled to assess the claim based on the medical information received during the claims process. In this instance, the Hospital Claim Form was received for the First Complainant's procedure from which I note that in the "**Symptoms**" section, in response to the question "Duration of symptoms prior to this?" the response given was "**18 months**". It is evident that the First Complainant signed this form confirming this detail.

Having considered the content of the Hospital Claim Form, I take the view that the Provider was reasonably entitled to conclude that the procedure in question was for a pre-existing condition and therefore the cover was subject to a two year upgrade waiting period for this private hospital. Consequently, as the Complainants were subject to a 2 year upgrade rule for any pre-existing condition, which had not yet been fully served at the date of the medical procedure in question, the Provider was reasonably entitled, based on the information provided in the Hospital Claim Form, to decline the First Complainant's claim on the basis that the procedure in question was not covered by their health insurance policy. I cannot find any wrongdoing on the part of the Provider in declining the claim on that basis.

I am aware that the First Complainant has referred to a subsequent telephone conversation which took place with a Provider representative on 18 July 2018 during which the First Complainant had said

> "I clearly stated that my SYMPTOMS had started "*about a year ago", which is well after my change of cover on the 8th February 2017. I was reassured that I would be covered on that basis.*"

The Provider had submitted the **file notes** made by its representatives in relation to the content of the telephone call which took place on 18 July 2018. These record that the First Complainant sought information in relation to cover for procedure codes "*5312, 5314, 5337, [Private Hospital],[Consultant]*".

The Provider representative informed the First Complainant that "*if the condition started before the 8/2/17 we would need to check your previous cover*", to which the First Complainant replied "*no no this is the start*".

The Provider's representative informed the First Complainant "*this is provided the condition is a new condition since feb last yr so the consultant will send all that info in to us with the claim*".

I also considered the file notes in relation to a telephone conversation that took place on the **7 February 2017** between the Second Complainant and the Provider's representative when the policy was incepted. The Second Complainant contacted the Provider, which recorded that she sought:

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> "*to join* [the Provider] *healthcare under the* [Product Name]. *During this call* [the Provider] *advised the Complainants' that as they were gaining benefits on* [Product Name] *such as hi-tech hospitals, they would be covered on the* [Previous Provider] *lower level of cover for two years for pre-existing conditions. They were also advised that they were still serving their five-year waiting period for pre-existing conditions as they only had Irish health insurance since the* ***8/02/15*** *and therefore still had three years left to serve.*"

I noted from the documentation before me that that in correspondence between the Complainants and the Provider, the Medical Advisory Board independently assessed the information provided for review. The available documentation was evaluated by a Specialist in Neurological Surgery who determined that the Complainant

> *"had a long standing history of problems with cervical spine degenerative disease". It is noted that your "current presentation was a 3-4 year history of increasing clumsiness and weakness of the right leg and clumsiness in her hands" and "myelopathy has likely started 16 years ago with a prolonged period of stabilisation with subsequent recurrence and deterioration of symptoms from 3-4 years ago.*"

The General Rules Policy Booklet (page 5), under the heading Pre-existing condition stipulates:

> "***Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final***".

In the Provider's submissions the Provider has stated

> "*Based on the clinical information provided for this appeal our external medical advisor whose speciality was Neurological Surgery deemed the following to be the case:*
>
> *…. therefore her myelopathy has likely started 16 years ago with a prolonged period of stabilisation with subsequent recurrence and deterioration of symptoms from 3-4 years ago"*
>
> *Therefore, our medical advisors are of the opinion that the onset of this condition is even longer that the 18 months documented on the claim form, but the claim was rejected based on 18 months alone*".

On the basis of the evidence available, I accept that the Provider was entitled to decline the Complainants' claim based on the following reasons:

1. The Complainants only held Irish health insurance from the **8 February 2015** and the General Rules Policy Booklet (page 13) states that "*The pre-existing condition waiting period is the first five years of membership".* Therefore, at the time of the procedure in December 2018, they still had more than a year left to serve and would not be due to be fully covered by their policy until the *8 February 2020*.

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2. The Complainants were also subject to a two-year upgrade rule for any pre-existing condition for the private hospital in question. The General Rules Policy Booklet (page 13) states that "*The additional cover waiting period is the first 2 years following the change".* The Complainants therefore were also separately not due to be fully covered for the upgraded level of benefits until **7 February 2019**.

I am satisfied accordingly, on the basis of the evidence before me, that in declining to admit and pay the claim, the Provider acted in accordance with the terms and conditions of the Complainants' policy and for the reasons stated above, this complaint cannot be upheld.

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

25 August 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.