An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0306
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a Private Health Insurance Policy. The Provider against which the complaint is made is a broker.

The complaint is that the Provider:

- *"Downgraded"* the Complainants' health insurance by recommending a plan that was not suitable for their needs;
- Did not inform the Complainants that the recommended plan, Plan B, did not cover procedures in a certain hospital;
- Proffered poor customer service in respect of its response to the Complainants' complaint.

The Complainants' Case

The Complainants submit that the Provider "*changed*" their health insurance from Plan A to Plan B, despite previously recommending to the Complainants that they remain on Plan A, and, as a result, *"downgraded"* the level of cover provided.

The Complainants state that this resulted in them having to fully pay for a medical procedure that would have been somewhat covered under Plan A.

The Complainants states that when they raised the matter with the Provider, they did not receive a timely response from the Provider.

In an e-mail to the Provider dated **29 October 2018**, the Complainants set out their difficulties regarding a claim and the issues caused by the change of policy cover, as follows:

"… [the Provider] failed to inform me that this plan did not cover procedures in [X Hospital]. In order for my wife to have the second part of her surgery in the [X Hospital] I had to pay additional 5,500. € to [X Hospital]….".

The Complainants submit that in a letter dated **27 November 2017**, that issued prior to the recommended change of cover, the Provider had stated: *'I recommend you remain on your existing health plan for the coming year*'.

The Complainants question why then did the Provider changed the Plan and cause them financial problems. The Complainants state that all procedures under Policy A were covered, and as pensioners they cannot afford the expenditure incurred as a result of the change in cover.

The Complainants submit that they were unhappy with the Provider's communication, stating that the Provider *"failed to respond"* to the above mentioned e-mail. They further submit that they subsequently requested a final response letter from the Provider.

The Complainants want the Provider to reimburse them for the financial loss of €5,061.14 that they had to pay for the medical procedure.

The Provider's Case

The Provider, in its final response letter of **12 July 2019** states that after receiving the letter advising the Complainants to remain on Policy A, the first Complainant telephoned the Provider to discuss other options.

"…you telephoned our office on the 6th December 2017. You spoke with my colleague C.. and requested other options."

In respect of the advices given in relation to Plan B, the Provider states:

"[The agent of the Provider] then proposed the [Plan B] as an alternative. The reason why this was offered as an alternative was to provide a premium saving, the ability to claim money back for consultant's fees and other medical expenses without an Excess. Following this discussion you decided to switch to [Plan B]."

In respect of the procedure undertaken at the Hospital, the Provider states it was advised to the Complainants by e-mail and telephone prior to the procedure being undertaken that the Plan would not cover the procedure in the particular hospital, but that full cover,

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remaining under the care of the specialist, was available in other hospitals. The Provider's position is that it was the Complainants' decision to continue to attend at the hospital where the procedure was not covered.

Timeline of events

27 November 2017 – the Provider posted renewal recommendation to the Complainants advising that they stay on their existing plan (Plan A).

29 November 2017 - Renewal Notice for Plan A posted from Underwriter to the Complainants. Including Statement of Suitability and Table of Cover.

6 December 2017 Call 14:19 – The Provider states that the First Complainant called, wanted to change things around, suggested Plan B, went through the plan and they were both very happy to switch. Saving €105.40.

27 December 2017 - Renewal Notice for Plan B posted from Underwriter to Complainants. Including Statement of Suitability and Table of Cover

29 December 2017 - Renewal Confirmation for Plan B posted from Underwriter to Complainants. Including Member Handbook

15 January 2018 Call 17:39 – The Provider states that the First Complainant wanted options to reduce premium considering switching to another plan but will decide by Friday. Further saving €217.20 – client did not call back therefore remained on Plan B

16 July 2018 – E-mail from the First Complainant following the Underwriter advising him that Procedure Code **** was not covered in chosen hospital.

17 July 2018 – Provider's reply to the First Complainant's email clarifying cover on Plan B and that procedure was not covered on Plan A either.

19 July 2018 - Email from the First Complainant requesting to be put back onto Plan A

19 July 2018 – Provider's reply to the First Complainant advising the Provider would ask Underwriter to carry out his request to be put back onto Plan A

20 July 2018 Calls 1 and 2 - The Provider made a call to the First Complainant following emails listed above. The Provider advised the First Complainant that procedure his wife had in September was different as it was a special listed procedure, however procedure **** scheduled for Monday 23rd July was not, and therefore would not be covered by Underwriter in the chosen hospital. They explored options of performing procedure in hospital where it would be covered, but the First Complainant was not happy to re-arrange elsewhere. The Provider says that the First Complainant seemed to accept that it was not covered and was still going to go ahead with it, he will claim 20% back from revenue and send receipts to Provider to process claim for outpatient / day to day for 2018.

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30 July 2018 – E-mail from the First Complainant regarding confusion about excesses and update regarding switching back to Plan A

3 August 2018 – The Provider's reply to the First Complainant clarifying cover on Plan B and confirming not possible to switch back to Plan A

29 October 2018 - E-mail from the First Complainant stating 1) that the procedure that was not covered was the second part of previous surgery his wife had, and 2) that all procedures were in the hospital were covered on Plan A.

13 November 2018 - Email from the First Complainant due to no reply to email sent **29 October 2018.**

14 October 2018 – The Provider's reply to the First Complainant reiterating he was never on a plan with cover for anything other than day cases, cardiac and special listed procedures in high tech hospitals.

10 December 2018 - Email from the First Complainant to cancel Plan B

12 July 2019 Final Response Email sent to the Complainants following request from this office.

The Complaints for Adjudication

The complaint is that the Provider:

- *"Downgraded"* the Complainants' health insurance by recommending a plan that was not suitable for their needs;
- Did not inform the Complainants that the recommended plan, Plan B, did not cover procedures in a certain hospital;
- Proffered poor customer service in respect of its response to the Complainants' complaint.

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.

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

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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 **12 August 2021**, 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.

A Submission dated **13 August 2021** from the Complainants was received after I issued my Preliminary Decision to the parties. In this submission the Complainants expressed that they were hoping for a better settlement than that set out in my Preliminary Decision. This submission was exchanged with the Provider and an opportunity was made available for any additional observations arising from the additional submission. There were no further submission received from the parties. I have considered the Complainants' post Preliminary Decision submission and all the submissions and evidence in arriving at my final determination set out below.

The Provider states that its initial recommendation in **November 2017** to maintain Plan A was based on the Complainants' existing level of cover and market pricing. The Provider says that if there is a better plan for the same premium or the same plan for a lower premium it recommends a client to switch. The Provider submits that this was not the case at renewal **31 December 2017** therefore it recommended the Complainants stay on their existing level of cover.

It is the Provider's position that following a call from the First Complainant on **06 December 2017** requesting other options, the Provider explained the cover on Plan B which it says was better as the Complainants could claim Money Back on Day to Day Medical Expenses and the same level of hospital cover apart from the increased excess from €125 to €250 for an inpatient hospital stay in a private or high-tech hospital. The Provider's position is that there was no material change to the Complainants' circumstances, they were on the same level of cover prior to joining in 2012 and maintained that level of cover throughout the years. The Provider states that the only change related to pricing, due to price increases in 2017, Plan A went up €140 per person, as the Complainants were on a pension they were trying to keep the premium more in line with what they were already paying. The Provider asserts that, Plan B, although still an increase in premium from the previous year was the best option without reducing their cover.

As regards the Provider's handling of the Complaint, the Provider says it was first logged on **16 July 2018** and is still open on its complaints register. The Provider states that it is satisfied that it met its obligations. The Provider states it continuously kept in contact with and responded to the Complainants without any delay apart from the e-mail that the First

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Complainant sent on **29 October 2018** which, was flagged but overlooked for follow up in a timely manner and it was 12 working days before it responded.

As regards the resolution sought by the Complainant, the Provider states that the Complainants were aware that they were not going to be covered for the procedure in their chosen Hospital prior to going ahead with it. The Provider says the Complainants complied with the terms and conditions of their policy which requires them to confirm cover with the Underwriter in advance of the procedure. The Provider submits that following the telephone call on **20 July 2018** the First Complainant clearly understood that the Underwriter would not cover the procedure in question and that they were going to be fully liable for the subsequent hospital bill.

The Provider's position is that it has a strict *house view* whereby it never recommends a plan to clients on the basis that they have a certain percentage of cover. The Provider says that the level of cover on both Plan A and Plan B are the same in high tech hospitals, that is, fully covered with a reasonable pre-determined excess of up to €250 for day cases, together with cardiac and special listed procedures. The Provider submits that the fact that Plan A had 45% cover for other procedures in high-tech hospitals was never used as a reason for recommending a plan and was never said to the clients by the Provider.

The Provider states that had the procedure in question been the same as the procedure that was covered under Plan A in 2016 it would have been settled in full apart from an excess of €250 on Plan B instead of €125 excess on Plan A.

In the Complainants' submission **28 July 2020** they state that the only observation they would make is that the assertion in the Provider's response that the First Complainant called the Provider on **06 December 2017** to *"change things around"* is false and incorrect and they reject this. The Complainants state that they would challenge the Provider to furnish evidence to the contrary.

In the Provider's submission of **28 August 2020** it states: "It was not company policy to record calls in 2017, we have however always kept note of any contact made by or with clients and the outcome of the contact on their file".

The Provider submitted the note it says was recorded on 06/12/2017 at 14:19 which read:

> *"[First Complainant] called, wanted to change things around, suggested [Plan B], went through the plan and they were both very happy to switch".*

The Provider states that all documentation related to Plan B was posted to the Complainants, following receipt of the documentation by the Provider. The Complainants called again and considered downgrading cover. The note by the Provider on 15/01/2018 at 17:39 reads:

"[The First Complainant] considering switching to [other] plan but will decide by Friday".

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It is the Provider's position that the First Complainant made no further contact and therefore remained on Plan B.

In its submission of **03 June 2021** - The Provider says that a Statement of Suitability was not sent by the Provider to the Complainants as it was included in the documentation from the Underwriter.

Analysis

The Provider does not have a recording of the two telephone calls of **06 December 2017** and **15 January 2018** where the Provider says the Complainant was seeking alternative cover to that which was already in place. The Provider states *"It was not company policy to record calls in 2017"*, but that it kept a system note of the calls.

It is disappointing that the Provider did not follow up those unrecorded telephone calls with a written correspondence from it directly to the Complainants, setting out what was discussed and agreed in the telephone call.

In any follow up written correspondence after such a change of policy cover, I accept that a comparison between the current policy cover with the cover being provided under the new plan, would reasonably have given greater information to the Policyholders as to the changes in cover that would result. The comparison could have set out for example: ***"With Plan A, you retain ...."*** versus ***"With Plan B, you no longer have ...."***.

The evidence shows that the Underwriter sent the Complainants a Statement of Suitability letter dated **27 December 2017**. I would have expected that such a letter should have issued directly from the Provider, as it was the Provider who was recommending the change of cover and not the Underwriter. The Provider's explanation for this is that it was the procedure at this time for the Underwriter to send out the Statement of Suitability. It is difficult to accept that the Underwriter was the appropriate party to do this, when it had not had the discussion on suitability directly with the Complainants as to what their needs and requirements were, in relation to the health cover.

I accept that a greater communication was required, where the Complainants' health cover is being changed from what had previously been in place for some years.

Ultimately, with any change of health plan cover, there is going to be differences in what level of cover is provided. There are going to be advantages and disadvantages with any change, whether it be as to the level of benefits being furnished, the level excesses that are to apply, or as to the price that is going to be charged.

I accept that the Provider could not exactly predict the most appropriate cover here, unless it knew all the information as to the planned future procedures and where they were to be carried out.

In my Preliminary Decision, I indicated that I considered that a sum of €500 compensation was merited for the identified failures and shortcomings of the Provider in respect of its

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communications on suitability and comparison of plan covers, its lack of follow up by way of written communication to the Complainants on the advises that were given in the unrecorded telephone calls and its delay in initially responding to the Complainants' concerns. The Complainants in their post Preliminary Decision submission expressed dissatisfaction with this sum and sought greater compensation. However, I remain of the view that €500 is fair and reasonable in all the circumstances of this complaint.

For the reasons set out in this Decision I partially uphold the complaint, and I direct the Provider to pay a sum of €500 (five hundred euro) in compensation.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g)*** as the conduct complained of was otherwise improper.
- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €500, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

08 September 2021

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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.