An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0428
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Complaint handling (Consumer Protection Code)
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the Complainants' health insurance policy held with the Provider.

The Complainant's Case

The Complainant submits that he switched his health insurance policy, from his previous provider to the respondent Provider on the **29 April 2019** as the Provider has walk in clinics. He submits that before changing his policy he had attended the Accident and Emergency department in a Private Hospital A (Hospital A) regarding issues with his breathing. The Complainant submits that, at the time, the treating doctor in Hospital A "*suggested as [a] precaution*" that he have a "*Stress ECG*" done, which he had done "*towards the end of April in the* [Hospital A]". Following the receipt of the results, he was told he "*should consider having an angiography*."

The Complainant states that he had this procedure in Hospital A "*towards the end of June 2019*" and that the results showed that he "*needed a stent*". The Complainant states that he was refused cover for the procedure in Private Hospital B (Hospital B) because the Provider said that he had a pre-existing condition before upgrading to the Provider and as per terms and conditions of the policy, any claim would be subject to pre-existing condition limitations, as outlined under the upgrade rule.

The Complainant submits that he received an email from the office of the doctor treating him at Hospital A, dated **20 August 2019,** which outlined that he may not be covered and he should contact his health insurance company:

> "*… [A]s your insurance cover was started on 12.04.2019 and your condition is documented in the Emergency Department here as starting on 14.03.2019, it would look like you may not be covered as you have a waiting period for pre-existing conditions until 2021*"

The Complainant asserts that he was caught "*in no man's land*" because under the previous cover with previous provider he had 65% cover in Private Hospital C (Hospital C) for the proposed treatment and under his current policy with the Provider, he has cover in Hospital B but only if the condition is deemed a new condition.

The Complainant submits that he contacted the Provider on **13 September 2019** querying cover in Hospital C where he was scheduled to have the treatment but he was informed by the Provider agent that for Hospital C he "*did not have any cover*" under his current policy. The Complainant states that the Provider has poorly administered his health insurance policy including giving incorrect provision of information regarding the level of cover under the policy, and the claim process.

The Complainant submits that he was left with no choice but to self-fund the treatment in the United Kingdom (UK). The Complainant now seeks to be compensated on a "*pro rata"* basis for expenses incurred, maintaining that the condition was not pre-existing and that there was a legitimate claim for cover that was denied, due to miscommunication on the part of the Provider.

The Complainant submits that he was not aware of the 'prior approval rule' and states that what he did was perfectly reasonable and he should be compensated for expenses incurred retrospectively as he was wrongfully denied cover and forced to become a "*self-funder*".

<u>The Provider's Case</u>

The Provider says that its records indicate that the Complainant purchased his policy online on the **29 April 2019** following which documentation was issued to the Complainant including the terms of his policy. The Provider submitted five audio recordings of phone calls in relation to the Complainant's complaint.

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The Provider states that the Complainant held private health insurance for many years and all waiting periods had been served. It says however, that the Upgrade rule is relevant as it states that:

> "*If you transfer from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, benefits will only be payable up to the level of cover offered by that contract*".

The Provider says that any higher benefits under the new cover do not become available for a pre-existing condition for two years from the date of the upgraded cover. As a result, claims relating to pre-existing conditions are assessed on the basis of the policy cover held with the previous insurer, subject to the terms and conditions of the policy with the Provider.

The Provider submits that on the **9 September 2019** the Complainant called the Provider to advise that he may need an angioplasty procedure under a named Consultant and the question arose whether this procedure was subject to the pre-existing condition upgrade rule. The Provider submits that its agent explained that pre-existing conditions are determined based on medical information submitted from the Complainant's treating doctor. The Provider states that its agent explained the 'Upgrade Rule' and the Complainant stated that he would check his level of cover with his previous insurer.

The Provider submits that the Complainant contacted it on the **13 September 2019,** querying cover in Hospital C after Hospital C advised him that he "*did not have any cover*" there under his current policy. The Provider states in relation to this telephone call in submissions to this Office that:

> "*The conversation then moved to your entitlements in* [Hospital B] *and it was confirmed that for a new condition, you would have cover in a semi-private room…"*

The Provider further states:

> "*We know that you did not have cover for* [Hospital B] *under your* [previous provider] *plan, therefore if your condition was pre-existing, you would not be covered.*
>
> *You* [the Complainant] *stated that as you had a 70% blockage, it would not be feasible for the consultant to say it wasn't a pre-existing condition. The* [Provider's] *advisor outlined that we were not medical professionals and therefore the claim would be assessed, based on the medical information submitted from the consultant*"

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The Provider submits that the Complainant called the Provider three more times by which time it transpired that he had already had the treatment carried out in the UK. The Provider states that its agents informed the Complainant that no medical information had been received at any point from the Complainant and no determination as to his condition being pre-existing or not, had been made by the Provider.

The Provider says that, as per terms and conditions, any treatment abroad requires prior approval. As prior approval had not been sought, the Complainant was asked to arrange a prior approval request from his consultant and that a form would be sent "*on this occasion*".

The Provider submits that during the final call with the Complainant about this claim, the Complainant was informed that there would be no possibility for claiming under the cover for treatment abroad carried out for which prior approval was not sought, in line with the prior approval terms and conditions of the policy.

The Provider contends that no claim or medical information has been submitted for review and therefore at no point was it indicated to the Complainant that the Provider had made a determination whether or not the condition was "pre-existing". The Provider maintains that cover was not refused in any way, as no claim had been submitted.

The Provider asserts that no claim can be made in relation to treatment carried abroad without prior approval.

The Provider submits that the Complainant incepted his policy online on the **29 April 2019** and in so doing he agreed to the terms and conditions of the particular plan and that the rules and terms and conditions of the cover were issued along with the Table of Benefits for the policy level of cover purchased by the Complainant. The Provider submits that a policyholder is encouraged to review the terms and conditions of the policy and if he/she is not happy, he/she may cancel the policy withing 14 days.

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused cover for the Complainant's treatment and unreasonably refused to compensate the Complainant for expenses he incurred for medical treatment carried out abroad.

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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 **26 October 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.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Chronology of Events

- **14 March 2019**: The Complainant attended A & E in Hospital A complaining of chest pains.
- **29 April 2019**: The Complainant incepted the health insurance policy with the Provider.
- **20 August 2019**: The Complainant received an email from his Consultant's office informing him of not having cover in Hospital A under the current policy and that as the condition was pre-existing, according to their records, he may not be covered in Hospital B either.
- **9 September 2019**: The Complainant called the Provider to query cover for treatment from the Consultant.
- **13 September 2019**: The Complainant called the Provider to enquire about his level of cover. At this point the Complainant had been informed by Hospital C (where he had 65% cover under his previous health insurance plan) that he had no cover under his current plan.

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The Complainant was informed that there was no cover for the procedure in Hospital B if it was a pre-existing condition and no cover in Hospital C because that hospital was not covered under his current policy. The Complainant said that he would get the exact codes of the Procedures and ring back the next day.

- **29 October 2019**: The Complainant called the Provider and said that he had undergone the required medical treatment in the UK.
- **6 December 2019**: The Complainant called the Provider to enquire about making a claim under his policy.

Policy Terms and Conditions

I note under the Terms and Conditions of the policy it states that:

> *"2. c) When determining whether a Medical Condition is Pre-existing, it is important to note that what is considered is whether on the basis of medical advice signs or symptoms consistent with the definition of a Pre-existing condition existed rather than the date upon which You became aware of the condition or the condition is diagnosed.*
> *Whether a Medical Condition is a Pre-existing condition will be determined by the opinion of Our Medical Director"*

And:

> *"2. f) If You transfer from a health insurance contract with another insurer registered in Ireland under the Health Insurance Acts, benefits will only be payable up to the level of cover offered by that contract. Additional benefits will be subject to Rule 3(b)."*

Further it set outs that:

> "3.*b)… If the Policyholder upgrades the Plan (i.e. purchases cover for additional benefits), the payment of additional benefits will be subject to the following waiting periods...*
>
> > *b) i) If the Policyholder (or authorized person- see Section 10) changes the Plan and any of the individuals included on the Policy receives treatment during the applicable Waiting Period for a Medical Condition which in the opinion of Our Medical Director they already had on the effective date on which the Plan was changed and if the benefit payable for the claim is higher on the new Plan, We will only pay the benefits <u>which We would have paid if the Plan had not changed</u> until the applicable waiting period has expired."*

[<u>Emphasis added</u>]

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The audio recordings submitted in relation to this complaint have been carefully considered. I note that on the **20 August 2019** the Complainant received an email from his Consultant's office to inform him that he was not covered in Hospital A or Hospital C under his current policy and that his condition was documented in Hospital A to have started prior to the inception of the new policy with the Provider and therefore, it may not be covered by the Provider due to the pre-existing condition 2 year waiting period. The Complainant was requested to check his level of cover directly with the Provider himself.

I note the Complainant telephoned the Provider on the **9 September 2019** and **13 September 2019** to enquire about his cover for the treatment from his Consultant. The subsequent telephone calls on the **29 October 2019**, **6 December 2019** and **28 January 2020** relate to the Complainant seeking to be compensated after already having had the treatment carried out abroad.

I note that during the first call on the **9 September 2019** the Complainant stated that he understood from his Consultant that the Provider has *"raised that this was a pre-existing condition and raised issue over the attendance for chest infection*" prior to the inception of the current policy.

The Provider's agent asked the Complainant on numerous occasions where the Complainant was getting the information that the Provider had deemed his condition pre-existing. The Provider's agent states that:

> "*We usually base if it's pre-existing on medical information received from your consultant once a claim comes in*".

I note the Provider's agent informed the Complainant that no claim had yet come in on behalf of the Complainant. Furthermore, I note the Provider's agent went on to explain the upgrade rule and stated that:

> "*Whatever* [you were] *covered for before, you retain that level of cover if it's pre-existing*".

I note from the audio evidence provided that it was the Complainant who raised the fact that the condition may be "*pre-existing*" for the upgrade rule, based on information he received from his Consultant.

I note that the Complainant telephoned the Provider on the **13 September 2019** to seek clarification in relation to cover under his policy, as he was scheduled to have the treatment in Hospital C, which was covered under his old policy.

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The Complainant asked how the Provider would determine if the condition was pre-existing or not and was informed by the Provider's agent that the claim would usually come in after the procedure had been carried out and based on medical information provided, the determination of whether it was pre-existing or not, would be made:

> "*It will come down to what the consultant says where he deems its pre-existing or not. On the claim form* [it] *asks when first visited him and how far back it has been going, that is literally what we go off*"

I note the Complainant went on to state:

> *"I don't think its credible to say it* [the condition] *started on the first of May I don't think… that's not a flier … I have 70 % blockage I didn't get 70% blockage from the first of May to date I don't think, that is not a flier its simply not credible. It is a pre-existing condition everyone is saying it's a pre-existing condition*"

The Provider's agent replied:

> "*We don't make that determination,* [we are] *not medical professionals*".

The Provider's agent repeated that whether it was a pre-existing condition or not, would only be assessed based on medical information received, terms and conditions of cover and the Provider did not determine this until a claim was received. The Provider's agent informed the Complainant that usually the claim form comes in, after the treatment has been undergone. The Complainant enquired about this process and asked if he was leaving himself exposed to a potentially large medical bill. The Provider's agent told the Complainant that he did not "*know level of cover on last policy*" to be able to determine whether the Complainant would be covered if the condition was to be found to be "pre-existing". I note the Complainant details that on his last policy he was covered in Hospital C at 65% cover but not covered in Hospital B to which the Provider stated that:

> "*This is where it gets difficult because of this policy you're not covered in* [Hospital C] *but are covered in* [Hospital B]*…*
>
> *No easy way around it essentially…. we won't set the pre-existence date whether it is or not … we don't know if pre-existing. I can't see your previous cover but on the assumption that it doesn't cover* [Hospital B] *you won't be covered with this consultant anywhere essentially if he doesn't work out of* [Public Hospital A] *and* [Hospital C] *is not on the policy you have with us now and* [Hospital A] *is excluded anyway, we are going on the assumption that it is a pre-existing condition this Consultant is out essentially."*

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I note that the Provider stated that the Complainant needed to find a hospital that was covered by both the old and his new policies. The Provider stated that with the Consultant, the Complainant could have the treatment in a named public hospital. The Complainant set out that he was aware that the Consultant did not work out of the named public hospital. The Complainant stated that he seemed to be "*getting stuck between the hospitals*".

I note that the Complainant called the Provider on the **29 October 2019** and it transpired that he had already had the procedure done in the UK approximately **6 weeks** before that.

I note that from the call on the **29 October 2019,** that the Complainant sought to state that the condition was not pre-existing and that the Provider wrongfully made the determination that it was pre-existing and wrongfully denied him cover. I note the Complainant expressed frustration as a result of feeling that he had been caught between the two insurers.

I note that in response, the Provider's agent stated that no claim had been received on behalf of the Complainant and so the Provider had no information in relation to the Complainant's case. The Provider's agent asked the Complainant who had informed him that it was a pre-existing condition and asked if it was the previous insurer that had made the determination. The Provider's agent explained that no one could have said if it was pre-existing or not without medical information and repeated that the Provider had received no medical information. The Provider's agent went on to explain the rules in relation to prior approval for treatment carried out abroad.

I also note the details of the Complainant's call to the Provider on **6 December 2019** when the Complainant stated that the Consultant would not now say whether the condition was pre-existing or not. The Complainant outlined his disappointment as he submitted that, had he stayed with his previous insurer he would have had cover in Hospital C at 65%.

The Provider's agent informed him that under the Upgrade Rule he would "*never lose what he had*" under the previous cover. The Complainant explained that he was scheduled to have the treatment in Hospital C and approximately a week beforehand he had been informed by Hospital C that he had no cover. The Complainant stated that he was caught in the middle with no cover. The Provider's agent said that the Complainant would have had cover in Hospital B. The Complainant advised that he gave his policy details to the Consultant's office who enquired on his behalf, and informed him that he had no cover in Hospital B.

I note the details of the Complainant's call to the Provider on the **28 January 2020** seeking to retrospectively make a claim under his policy for the treatment he had abroad. The Complainant outlined his position in that he felt stuck between the insurers with a "*life threatening condition*" and felt that he had had no other option than to seek treatment abroad.

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The Provider informed the Complainant about the terms of his policy in relation to prior approval for treatment, to be carried out abroad. In reply to the prior approval for treatment abroad requirement the Complainant stated that he didn't "*need permission to get on a plane*" and he felt that what he did was perfectly reasonable and he wished to submit a formal complaint.

Having considered all of the information supplied in evidence, I accept that it was reasonable for the Provider to decline cover for the treatment the Complainant had in the UK because the Complainant did not seek prior approval as set out under the terms and conditions of his policy with the Provider. I note that during the final call before going to have the procedure in the UK, the Complainant did not query cover for treatment abroad. The Complainant was provided with all the information in relation to the terms and conditions of his policy on the date the policy was incepted.

I accept that the Complainant did not need the Provider's approval to "*get on a plane*". Rather, for the purpose of ensuring that the cost of treatment abroad would be covered, the approval he required was one confirming cover for the treatment he intended to undertake abroad. In this instance however, he did not raise this with the Provider prior to travelling abroad or before undertaking the procedure in question. Accordingly, I cannot find any wrongdoing on the part of the Provider in declining the Complainant's claim to be compensated retrospectively for the cost of treatment carried out abroad, without prior approval.

I note that during the telephone call on the **13 September 2019** when the Complainant queried his policy cover, it appears that the Complainant had already been informed directly by Hospital C that he had no cover for the treatment he was scheduled to have a week later, and he was seeking clarification from the Provider.

As quoted above from the audio evidence, the Provider's agent informed the Complainant that he would have no Cover in Hospital C, although he had held this cover under the old policy. This was because this hospital was not covered under the policy with the Provider. I note that the Provider's agent stated that the Provider does work with Hospital C, but that cover was not available for the Complainant under his upgraded policy with the Provider, notwithstanding that the Complainant should have been in a position to recover benefit on the basis of his previous cover held with the previous health insurer, before his "upgrade" to the Provider. Having listened to the recording of this telephone call I am of the opinion that it was understandable for the Complainant to believe that he held no cover for any private hospitals and that his only option was to have the treatment in a public hospital, under a different consultant.

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I take the view that there was a failure by the Provider to correctly and clearly inform the Complainant as to his then current cover, which under the terms and conditions should have provided cover "*payable up to the level of cover offered by that [previous] contract*". Under the terms and conditions of the policy with the Provider it is unclear why he was told that he had no such cover, as a result of changing provider. The Complainant was entitled to expect, when querying his cover that all communication in respect of his policy would be addressed by the Provider with due skill, care and diligence as required under the General Principles of the Consumer Protection Code 2012.

In those circumstances, I take the view that the Provider failed to communicate clearly to the Complainant, as to the level of benefit he was entitled to, for treatment (based on the previous level of cover held for Hospital C with his previous insurer) and I am conscious that this failure occurred at a time when he was encountering medical issues which required prompt treatment. In my opinion, the Provider's conduct in that regard was unreasonable and unjust within the meaning of ***Section 60(2)(b***) of the ***Financial Services and Pensions Ombudsman Act 2017***. It is important to bear in mind that clear information at such a critical time, is an absolute necessity for policyholders who are seeking to explore their options for medical treatment. As a result, I consider it fitting, in the circumstances, that the Provider make a compensatory payment to the Complainant for the confusion and inconvenience caused by its poor communications with him in this matter, as detailed below.

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)(b).***

- 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 Complainant in the sum of **€3,000,** to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant 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.***

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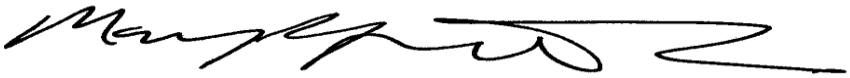
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

18 November 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
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.