An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0451
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the conduct of the Provider in declining the Complainant's claim under her health insurance policy in relation to treatment.

The Complainant's Case

The complaint relates to a health insurance policy incepted by the Complainant on **8 July 2017.**

The Complainant was admitted to a private hospital on **24 October 2018** and discharged on **23 December 2018**. A claim submitted by the Complainant was later declined by the Provider on the grounds that the five-year pre-existing waiting period had not been served by the Complainant, in order to be covered for the cost of treatment for a pre-existing condition.

The Complainant states that the procedure she needed on **24 October 2018** was related to a "*repair of damage*", following "*medical treatments*" by a medical professional after she commenced her policy with the Provider. She disputes that she had a pre-existing condition. The Complainant believes the claim should therefore be admitted for payment by the Provider.

The Provider's Case

The Provider contends that at the time of the claim, the Complainant had not served the required "*five year waiting period served*" from when the policy cover was incepted on **8 July 2017.**

The Provider states that the Complainant was admitted for "*Arthroplasty of the left hip*" on **24 October 2018**. The Provider confirms in its final response letter dated **10 May 2019**, that the Complainant had been "*referred*" to orthopaedic surgeon Professor M on **3 July 2017**.

The Provider says this referral arose from the Complainant "*presenting to the ED on 29 June 2017 with ongoing pain in her left hip*."

The Provider submits that the Complainant "*is known to Professor M services for many years*."

The Provider advised the Complainant that following her appeal and its investigation into the claim, it is unable to admit the claim for benefit, in accordance with the "*pre-existing condition waiting period*" which forms part of the scheme rules.

The Complaint for Adjudication

The complaint is that the Provider incorrectly declined to pay the [private hospital] for treatment the Complainant received in the period between **24 October 2018** and **23 December 2018**.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

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A Preliminary Decision was issued to the parties on **4 November 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.

Correspondence between the parties

The Provider has stated that the Complainant's plan was effective from **8 July 2017**.
On **8 July 2017** the Complainant telephoned the Provider seeking a quote for insurance:

Provider's Agent: "*you will be covered immediately for any new conditions...for any pre-existing condition there's going to be a waiting period for 5 years […] we don't cover anything pre-existing for the first 5 years*."

Complainant: "*I have an orthopaedic condition...and I'm always in and out of hospitals*"

Provider's agent: "*For that condition, your health insurance won't have effect for 5 years*"

On **12 July 2017**, the Complainant called to confirm that she would take out the plan.

Provider's agent: "*Any pre-existing condition for the last 5 years would not be covered.*"

Complainant: "*I am covered now?*"

Provider's Agent "*...You're covered now...if the condition you're suffering from started after 8 July, we will cover it, but if it was before...* "

Complainant "*…it is for the same condition I had..*"

Provider's agent "*If it was something you were suffering from before taking out the cover we won't be covering it for the first 5 years of your health insurance*."

Complainant: "*I…only found out that I have fluid on the hip, and I have to go for an operation*."

Provider's agent: "*It would be up to your consultant as to when those conditions started…and the consultant's recommendations… Just because you*

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found out about it yesterday doesn't mean that that's when the condition started… you will be covered if those conditions started after 8 July…if the consultant says those conditions started on, let's say 20 June, that's before joining so they won't be covered for 5 years."

Complainant: *"Ok that's sound".*

A copy of the General Rules booklet ("the policy document") was sent to the Complainant on **13 July 2017**. I note that the policy document at page 5, section 2 stated as follows:

"*Pre-existing policy condition*

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.

Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their decision is final.

At page 11 of the booklet, section 9 deals with what is not covered under the policy, and states:

"*The pre-existing condition waiting period is*

- *the first five years of membership*".

Finally, at page 44 of the booklet, it states:

"*Important information to note:*

Waiting periods…

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"

I note that on **5 August 2017**, the Complainant telephoned the Provider. She stated that she was in hospital and asked whether she was covered under the policy. She further stated "*I'm not covered for the that after five years"* when asked by the Provider's agent whether she was in hospital during the call.

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She added "*I was in hospital for another condition…"* but she then stated, "*I got burnt…and I want to go private to get a skin graft*".

The Provider's agent again advised "*because you were in hospital for the pre-existing condition…it would still be according to the primary reason you were in their in the first place…the claim in general wouldn't be allowed because it's a pre-existing issue*."

The Complainant's partner then spoke to the Provider's agent on this call and asked could she be treated for the burn injury. The Provider's agent asked for the Complainant's partner to confirm that the current burn injury had "*nothing to do with the current admission*" and if it did it would be "*rejected*". The Complainant's partner confirmed that the burn was a separate injury and the Provider's agent sought confirmation and certain documentation regarding this burn injury.

On **3 January 2018** the Complainant telephoned the Provider. On this call, the Complainant queried whether she was covered for "*two hip replacements*".
The Provider's agent stated that "*it would have to be a new symptom or new condition since the 8th July 2017 for to be covered... anything existing prior to that you would have to wait five years for it to be covered*".

On **10 January 2018** the Complainant telephoned the Provider and stated that she was undergoing surgery in a couple of weeks which she described as "*two hip replacements*." The remainder of the call was as follows:

Provider's agent	*"A hip replacement?"*
Complainant	"*Two*"
Provider's agent	"*Two hip replacements... Would you have the name of the consultant you're attending?"*
Complainant	"[Professor M]"
Provider's agent	"*when your symptoms are first being present...?"*
Complainant	"*the last few months*"
Provider's agent	*"... It's just if the consultant were to state on the claim form that your symptoms were prior to the 8th of July 17 you wouldn't be covered for that procedure for five years... But what I would recommend you do is give the consultant a call and get a procedure code from for that from him and ask him on what said date will he be putting on the claim form... and once you get those details give us a call and we'll be able to let you know if you're covered*."

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On **17 July 2018** the Complainant telephoned the Provider and again stated that she needed to have an operation in a couple of weeks regarding her hip. The Provider's agent requested the name of the consultant and procedure code in order to check if the Complainant was covered.

It is worth noting in respect of this call that the Provider's agent on numerous occasions indicated that she had difficulty in hearing and/or understanding the Complainant. Therefore, the Complainant put her partner on the phone who indicated that she had the symptoms for the "*last year or so*" but Professor M only decided to do the procedure "*today*".
I note that the Provider's agent then sought for the Complainant to clarify whether she had continuous cover, because this was a pre-existing condition. The Complainant responded by stating "*it's a new complaint*". The Provider's agent stated she required the Complainant to provide her with the procedure code before she could confirm cover and stated, "*if your symptoms were deemed to be pre-existing there is a five-year waiting period for pre-existing conditions*."

On **18 July 2018** the Complainant telephoned the Provider and gave the procedure code and name of the consultant. The Provider's agent asked when her symptoms began to which the Complainant replied "*last year*" to which the Provider's agent replied "*… joining date is the 8 July 2017. The symptoms began before then you wouldn't be covered at that moment because you're still serving your five year waiting period for pre-existing conditions*." The Complainant replied, "*it started after*."
The Provider's agent stated that the consultant would be the one that would indicate "*the onset start date on the claim form*". When asked by the Complainant, the Provider's agent also stated that the private hospital in question would be expensive if there was no insurance cover.

On **17 October 2018** the Complainant again telephoned the Provider to see if she was covered for the operation on **24 October 2018**. When asked by the Provider's agent for the procedure code, the Complainant stated, "*I gave you that before, I was covered yeah…I am covered*". The Provider's agent, after receiving the code from the Complainant stated, "*I see you advised my colleague that it was a new condition since you joined ourselves…so the symptoms started after 8 July 2017?*" to which the Complainant replied "*yes*". The Provider's agent also stated, "*just to advise, if the condition is deemed to be pre-existing before you joined us it won't be covered by your health insurance policy"* to which the Complainant stated *"yeah but it's not"*.

The referral letter from the hospital dated **4 July 2017** states as follows

> "*[the Complainant] presented to our ED on 29/06/17 with ongoing left hip pain for the last 2 weeks. she is known to [Professor M's] Service for many years. She is a background of cerebral palsy with left hip dysplasia and scoliosis.*

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On examination there was tenderness over that trochanteric region, anterior femur and loss tender over the interior tibia. there was a decreased range of motion in the left leg with about 30 degrees of hip flexion. There is no overlying erhythmia."

I note that on the claim form dated **27 December 2018,** which was completed by Professor M, it stated the Complainant was admitted into the private hospital on **24 October 2018** for the procedure and discharged on **23 December 2018**. The admission was classed as "*elective*" on the claim form and the Complainant elected to be a private patient of Professor M. The nature of the presenting symptoms was "*left hip pain – known cerebral palsy*". On the form, the date Professor M first saw the patient with symptoms was **September 2018**. The duration of the symptoms prior to this was indicated as four weeks.

On **25 January 2019**, the claim form for payment under the policy was processed by the Provider (this is based on the Provider's contact history log provided in evidence to this Office).

On **1 April 2019**, the Complainant's claim was rejected by the Provider. The reasons given were as follows:

"*From the information we received with the claim, the symptoms of the condition were present before joining [the Provider]. Therefore, a pre-existing condition waiting period applies and unfortunately we are unable to pay the claim on this occasion*."

After an appeal was lodged by the Complainant, on **10 May 2019** the Provider sent the following letter rejecting the appeal:

- "*On 03 July 2017. You were referred to [consultant] in relation to on-going left hip pain. The referral letter documented the following "[the Complainant] presented to our ED on 29/06/17 with ongoing left hip pain for the last 2 weeks. she is known to [Professor M's] Service for many years. She is a background of cerebral palsy with left hip dysplasia and scoliosis. On examination there was tenderness over that trochanteric region, anterior femur and loss tender over the interior tibia. there was a decreased range of motion in the left leg with about 30 degrees of hip flexion. There is no overlying erhythmia…[the Complainant] and her family are very keen to be seen and assessed by yourself a she has been under your care in OPD and CRC previously."*
- *On 08 July 2017 you commenced cover with [the Provider]. On joining you were subject to a 5 year pre-existing condition waiting period.*
- *On 24 October 2018 you were admitted to the [private hospital] for arthroplasty of your left hip, prompted by your diagnosis of "L hip chronic pain".*
- *Based on the information provided for review our Medical Advisors have concluded that the left hip pain, which prompted your admission, was consistent and ongoing prior to you commencing cover with [the Provider].*

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> *Additionally they have concluded that the referral process had been initiated prior to you commencing cover with [the Provider] on 08 July 2017*.
>
> *Therefore, based on the recommendations of our Medical Advisors, we are unable to consider the above claim for benefit in accordance with the pre-existing condition waiting period."*

The letter goes on to quote the policy and in particular "*Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final."*

I note that the expert clinical advisor report submitted from the medical advisor on behalf of the Provider states as follows:

> *"…when is the earliest date on which the patient presented with signs and/or symptoms of Left hip chronic pain?*
>
> *In a letter dated 3rd July 2017 there is a note describing the patient's visit at the emergency department the 29th June 2017. At the time the patient had on-going pain from the left hip since 2 weeks. Therefore, an approximate date for presentation of pain from the hip is around 15th June 2017.*
>
> *Please provide an approximate time frame during which it is likely the patient would have first experienced symptoms related to Left hip chronic pain?*
>
> *She is known to have a left hip dysplasia since before even if her pain got worse in June 2017. At the time the subluxation was confirmed on CT-scan. However, the subluxation does not appear suddenly in dysplasia of the hip joint, but slowly during months or years. Therefore is it possible [sic] the patient had symptoms from her left hip long time before she presented at the emergency department the 29th June 2017, also based on that the dysplasia was known since before."*

The Complainant in the complaint form to this Office stated, "*I dispute that I had pre-existing condition – later operated on in Oct 2018 – due to treatment by a medical professional followed by joining [the Provider] resulted in the need for repair of damage*".

The Provider has submitted that it is satisfied that, based on the clinical notes and the referral letters, this is a proven pre-existing condition for which the symptoms had begun prior to the Complainant's date of joining on **8 July 2017**. It submitted that the claim was assessed correctly and should remain rejected.

The Provider has stated that there is nothing in the Complainant's notes to support the statement that the procedure she needed on **24 October 2018** was related to "*repair of damage*" following "*medical treatments*".

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In a letter dated **9 February 2021**, Professor M who treated the Complainant during her stay in the private hospital stated as follows:

> "*This lady suffers from Cerebral Palsy, is a non ambulator and is known to have had a dysplastic left hip for years. However, the hip became painful enough to warrant surgical intervention in 2018. She was referred for total hip replacement to [separate consultant] who demurred and therefore was admitted to the [private hospital] for Excision Arthroplasty in October 2018.*
>
> *Prior to admission we insisted that she check with [the Provider] that she was covered for same and we were reassured on multiple occasions that she was covered for same and to my understanding the [private hospital] also accepted that she was covered for that procedure*.
>
> *To be clear therefore this lady certainly had a pre-existing condition, i.e. Cerebral Palsy and had experienced occasional discomfort in her hip which in many patients with Cerebral Palsy is intermittent and mild and does not require surgical intervention. However, in her particular case she developed a new condition as it were with severe arthritic pain in the left hip, necessitating surgery and those symptoms evolved significantly subsequent to joining [the Provider] in July 2017*."

In a letter dated **12 March 2021**, the Provider responded to this letter provided by Professor M. The Provider stated that the said letter from Professor M "*confirms that the Complainant had a pre-existing condition prior to joining [the Provider]*". The Provider referred to Professor M stating in his letter that the Complainant had "*occasional discomfort in her hip*" which was "*intermittent and mild*" and that "*those symptoms evolved significantly*". The Provider stated "*therefore, these symptoms which existed prior to the Complainant joining [the Provider] were progressing and un-resolving*".

The Provider goes on to state:

> "*These symptoms were exacerbated over time which led to a referral letter being written on 03/07/2017 and stamped on 04/07/2017, which was also prior to the Complainant joining [the Provider]. This referral letter documents the Complainant "presented to our ED on 29/6/17 with on-going left hip pain for the last two weeks. She is known to [Professor M's] services of many years. She has a background of cerebral palsy with left hip dysplasia and scoliosis." It was these pre-existing symptoms which led to the procedure in the [private hospital] on 24/10/2018.*
>
> *[Professor M] states that the Complainant and the [private hospital] contacted [the Provider] to check cover for this procedure and that they understood and accepted that the Complainant would be covered. This is not correct. The [private hospital] did not call [the Provider] and the Complainant was advised that she subject to a 5 year waiting period for pre-existing conditions upon joining and also on every call where she contacted [the Provider] to check cover for any hip operations.*

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…The Complainant presented to [the public hospital] on 29/06/2017 with "on-going left hip pain for the last 2 weeks" and was referred to [Professor M] on 03/07/2017, prior to her joining date with [the Provider] on 08/07/2017. This clearly shows this is a pre-existing condition."

Analysis

I note that the relevant General Rules policy booklet states as follows:

"*Pre-existing policy condition*

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.

Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their decision is final."

At page 11 of the booklet, section 9 deals with what is not covered under the policy, and states:

"*Pre-existing condition waiting period is – the first five years of membership*"

Finally, at page 44 of the booklet, it states: "*Important information to note – Waiting periods*" and then "*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*".

It is clear, therefore, that the material issue in determining if cover applies is whether the Complainant's symptoms began before the inception of the policy on **8 July 2017**. If the symptoms began prior to that date, then the condition was "pre-existing" the policy start date, and the terms of the policy will not cover the Complainant, if the claim was made within five years of the inception of the policy.

I note the referral letter of **3 July 2017** which stated the Complainant:

"*presented to our ED on 29/6/17 with on-going left hip pain for the last two weeks. She is known to [Professor M's] services of many years. She has a background of cerebral palsy with left hip dysplasia and scoliosis."*

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I am satisfied that the wording of the policy is clear in stating that a pre-existing condition is:

> "*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.*"

Therefore, the central issue is whether the *"on-going left hip pain for the last two weeks, documented on 29 June 2017,"* can be reasonably considered to be a pre-existing condition which existed when the Complainant incepted cover on 8 July 2017.

The Provider's medical advisor report stated:

> "*In a letter dated 3rd July 2017 there is a note describing the patient's visit at the emergency department the 29th June 2017. At the time the patient had on-going pain from the left hip since 2 weeks. Therefore, an approximate date for presentation of pain from the hip is around 15th June 2017*."

Accordingly, the opinion of the Provider's medical advisor is that the there was a pre-existing condition. I also note the wording of the policy in this regard which states

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

I note the views of Professor M who stated that this was not pre-existing and the Complainant "*developed a new condition as it were with severe arthritic pain in the left hip*". I can see from the correspondence between the parties that the Provider considered and engaged with the views of Professor M and provided a detailed response, again reiterating that "*The Complainant presented to [the public hospital] on 29/06/2017 with "on-going left hip pain for the last 2 weeks.""*

It is clear from this response that the Provider took all the relevant information into account, and in particular the referral letter. Ultimately, under the policy, the decision of the medical advisors is final, and I am satisfied that the Provider's decision in that regard to reject the claim was not unreasonable, unjust, oppressive or improperly discriminatory, given the medical evidence available to it at that time.

As a result, though I sympathise with the very difficult situation the Complainant finds herself in following such a lengthy recovery from her hip surgery, I am satisfied that the Provider is entitled to decline the claim under the policy, on the basis that the treatment undergone by the Complainant was for a pre-existing condition, as defined within the policy.

Turning to the Provider's conduct in its dealing with the complaint, I have reviewed the telephone conversations and in particular the conversation prior to the Complainant entering into the policy cover on **8 July 2017.**

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I note that the Provider's agent clearly stated that:

> "*you will be covered immediately for any new conditions...for any pre-existing condition there's going to be a waiting period for 5 years […] we don't cover anything pre-existing for the first 5 years.*"

The Complainant also stated, "*I have an orthopaedic condition...and I'm always in and out of hospitals*", to which the Provider stated "*For that condition, your health insurance won't have effect for 5 years."*

There was also another telephone conversation of **17 October 2017**, which was just prior to her **24 October 2017** admission to hospital. During this call the Provider's agent, after receiving the procedure code from the Complainant, stated "*I see you advised my colleague that it was a new condition since you joined ourselves…so the symptoms started after 8 July 2017?*" to which the Complainant replied "*yes*". The Provider's agent also stated "*just to advise, if the condition is deemed to be pre-existing before you joined us it won't be covered by your health insurance policy*", to which the Complainant stated "*yeah but it's not*".

I am satisfied that this evidence shows the Complainant was informed of the important terms of the policy, regarding any "*pre-existing condition*" immediately before entering the policy and immediately before admission to hospital. There were also other calls between the Complainant and agents of the Provider when the agents of the Provider drew the Complainant's attention to the "*pre-existing condition*" under the policy.

Accordingly, on the basis of the evidence available, I am satisfied that the Provider drew the Complainant's attention sufficiently to the clauses in the policy regarding cover for a "*pre-existing condition*" and the five-year waiting period requirement, which would need to be met. In light of the entirety of the foregoing and bearing in mind all of the evidence put forward by the parties, I do not consider it appropriate to uphold this complaint.

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

26 November 2021

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

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