An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0035
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint is that the Provider wrongfully sought to change the level of cover available to the First Complainant on her health insurance policy from her renewal date, notwithstanding reliance on a level of cover which she had "*come to expect... as the norm*".

The Complainants' Case

The policy is held by the First Complainant and the Second Complainant is also covered. They are husband and wife. The First Complainant states that on **22 October 2019** she received an email from the Provider advising that the policy was due for renewal and on the next renewal date, **22 January 2020**, the Provider advised that there would be a change to the terms of the policy to the effect that "*your psychiatric cover will however be reduced from 180 days to 100 days*".

The First Complainant submits that she phoned the Provider and was informed that "*in order to keep my 180 psychiatric cover, I would have to increase my policy at a much greater expense from €3758.96 to €5003.84*". The First Complainant further submits that she was also offered an alternative to reduce some aspects of the policy like orthopaedic and ophthalmic cover in order to retain her 180 days allocation of psychiatric cover. The First Complainant contends that the first option is too expensive and that the second option would result in her losing two important elements of her coverage, especially as "*arthritis and cataracts both run in the family, so going forward I may only require cover for one or both of these issues*".

The First Complainant asserts that she has been suffering from various mental health issues for the past eight years. She also submits that this has involved a period of hospitalisation in **2013**, **2014**, **2015**, **2017** and **2018** for intense treatment which could not be treated as an outpatient or as day care attendee as suggested by the Provider in its final response letter. The First Complainant states that she has lost a number of family members through suicide.

The First Complainant further contends that the reduction in psychiatric cover has "*caused my symptoms to escalate*" and that her psychiatrist "*is very aggrieved that I and a lot of his other patients are being put into this stressful situation simply because* [the Provider] *change their policies whenever they feel like it*". The First Complainant further contended when making her complaint in January 2020, that she is on long term sick leave and in receipt of half a salary, which makes the increase of premium to retain the current terms an impossibility and that the **2020** premium would increase by an amount of €291.00 (two hundred and ninety one euro).

The First Complainant submits that while she understands that the policy is for a 12 month period and subject to change at renewal under the policy terms and conditions, she requests an investigation as to whether a "*drastic*" change in the reduction of psychiatric cover from 180 days to 100 days is fair and just and unbiased towards mental health sufferers. The First Complainant further submits that she has been a "*loyal customer of* [the Provider*] and have come to expect the 180 days psychiatric cover as the norm over that period*."

The First Complainant states:

> "*I feel very prejudiced against for having an illness that may require long term hospitalisation and would feel under severe pressure if I were to be hospitalised again in the future that I would have to get better within a certain time frame before my 100 days run out*."

The First Complainant maintains that it is "*morally and ethically wrong in changing a mental health sufferer's policy to less days in a psychiatric hospital*" and she seeks the Provider to reinstate the 180 days psychiatric cover to her existing health insurance policy at no additional premium.

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

The Provider submits in his final response letter dated **23 December 2019** that it understands that the First Complainant is unhappy regarding the reduction of psychiatric cover from the next renewal in 2020. The Provider submits that "*it is never our intention to cause any frustration to our members*" but that each renewal is for a 12 month period and the benefits offered on a particular plan are subject to change at the following renewal date.

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The Provider contends that it has reduced the number of inpatient psychiatric days covered by the Complainant's plan, from 180 days to 100 days

> "*as psychiatric care has moved away from inpatient based treatment. Psychiatric hospitals have evolved into offering daycare and outpatient programmes, where an overnight stay is not required, As well as community based services*..."

The Provider states that, following a review of its records of the First Complainant's previous inpatient admission, these have not exceeded 100 days per calendar year. A detailed list of dates and the number of inpatient days billed on the policy, is contained in its submission. The Provider further submits that:

> "*it is important to note that the treatment carried out on an outpatient basis for the approved day care programmes is not deducted from the 180/100 inpatient psychiatric days*".

The Provider states that while alternative plans are available that will maintain the 180 day psychiatric days "... *in order to maintain other important aspects of your cover, an increase in premium would apply*".

The Complaint for Adjudication

The complaint is that from the renewal date in January 2020, the Provider wrongfully sought to reduce the level of cover available to the First Complainant on her health insurance, notwithstanding her reliance on a level of cover which she had "*come to expect... as the norm*".

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 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 **6 January 2022**, 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.

Recordings of telephone calls have been furnished in evidence and have been considered.

Correspondence between the parties

On **22 October 2019** the Provider emailed the Complainant stating that its healthcare cover was due for renewal shortly and it would like to make her aware of some changes for the health care plan from the next renewal date. The email stated as follows:

> "*[the Provider's healthcare policy] will continue to provide you with same great hospital cover and will also have enhanced optical benefits and cover abroad... Your psychiatric cover will however be reduced from 180 days to 100 days.*
> *You'll have to access the following exclusive [the Provider] benefits and services:*
> *[redacted policies of the Provider]*
> *Rest assured, you don't need to do anything, as your policy would renew automatically. If however you have any questions, or you would like to discuss your options in more detail please call us."*

On **22 October 2019,** the First Complainant telephoned the Provider regarding the change in her policy. During this call, it was stated as follows:

First Complainant: "*what is the idea of changing it down?*
"

Provider's agent: "*that particular plan has gone to 100 days…it's gone to 100 days on an awful lot of other plans as well…it doesn't seem to be used a lot on the plans…*"

The Provider's agent then described another plan which she described as "*a better plan*" and "*more expensive*" which would, amongst other benefits, include the "*180 days*" for inpatient psychiatric care. The Complainant then queried various benefits of the plan proposed by the Provider's Agent, before asking was it more expensive. The Provider's agent stated that the new plan would cost "*€5,002*" and the plan she was currently on cost "*€3,468.80*". The Provider's agent then said it was "*lax on cardiac cover on older plan*". The First Complainant stated she was "*bitterly disappointed*" that the psychiatric care went from "*180 to 100 without any warning*" and she was "*really not happy*" and "*if you have a mental health issue, you need to know this is there if required*."

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On **22 October 2019**, the First Complainant spoke with a separate Provider agent during a telephone call. The First Complainant again asked why she was not able to have her existing plan with the 180 days cover for psychiatric inpatient care. The Provider's agent stated that "*it is a business decision, management have made that decision*."

During this call, it was stated as follows:

First Complainant: "*I may never need the 180 days…the fact you are taking it away from me is immediately making me panic…is setting me off and sending me on a downward spiral".*

The Provider's agent then stated that she was unable to change the policy herself and that it was an actuarial decision. The Provider's agent then offered to bring her through some other plans. The Provider's agent again stated that she was understood it was a shock to the First Complainant, but she was unable to do anything about it. The First Complainant again stated the "*100 days is panicking me*". The First Complainant stated the Second Complainant required orthopaedic and the Provider's agent advised that "*a fair compromise*" would be to look at two separate cover sets.

The Provider's agent then checked and stated the plan which would meet the requirements of the Complainants would come at an increased cost of €622.44 (six hundred and twenty two euro and forty four cent). The total for the new revised policy was quoted as €4381.40 (four thousand three hundred and eighty one euro and forty cent). This was calculated as (€2,500 which was one half the costs of the improved plan plus €1879, which was one half of the policy if it remained the same) If the First Complainant was to increase her cover only, it would cost €51.87 (fifty one euro and eighty seven cent). The First Complainant stated she would take time to consider her options and decide before the renewal date.
On **04 November 2019,** the First Complainant telephoned the Provider regarding the change in her policy. The First Complainant asked had the Provider "*revised*" the decision to reduce the decision to reduce cover from 180 days to 100 days, to which the Providers agent stated "*as of this moment... the drop is still going ahead*."

The First Complainant then queried the quotes she had been given previously by the prior Provider's agent if she were to change the Complainant's plans upon renewal. In particular the First Complainant queried what it would cost if her husband, the second Complainant, remained on the same plan, but she was to change the improved plan to include the 180 days for psychiatric cover. The Provider's agent stated that the price discrepancy the First Complainant spoke of was because she was using the figures from last year's renewal amount (2019) for the second Complainants' policy, but that "*there has been an increase across all plans this year*".

The Provider's agent stated that the correct quote for a renewal where the second Complainant would remain the same and the First Complainant would change to the improved policy was actually €3758.96 (three thousand, seven hundred and fifty eight euro).

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The First Complainant stated that she had been incorrectly quoted €3468.80 (three thousand four hundred and sixty eight euro) by an earlier Provider's agent as the cost of her renewal if the plan remained the same. The Provider's agent stated that this was an error and apologised for this.

The Provider's agent again quoted the correct amount for the new policy as €4381.40 (four thousand, three hundred and eighty one euro). I note that during the second telephone call dated 22 October 2019, the second Provider's agent indeed gave the correct figure of €4381.40, which was made up of the increased cost for the same policy for the Second Complainant, and the improved policy for the First Complainant.

The Provider's agent further advised that it was not possible to confirm what the benefits would be for the improved plan 12 months into the future, as the policies are 12 month contracts. The Provider's agent also explained to the First Complainant the upgrade rules.

On **11 December 2019**, the First Complainant telephoned the Provider and stated she wished to lodge a complaint. The First Complainant stated that "*they have taken away something that I had for 30 years*" and because she required hospitalisation throughout the year, "*this was having a huge impact on her mental health*". The First Complainant further queried weather a decision from this Office would mean that she would be allowed return to the original 180 days if she maintained her existing plan, to which the Provider's agent stated that "*that would be for the ombudsman to decide*".

The Provider's agent also stated that, following consultation with his team leader, he was going to send the complaints team the "*complaint for the 180 days*" and also that the alternative cover was far too expensive. The Providers agent also stated the issue surrounding "*misinformation for the price*" would followed up with the team, separate from the complaint. During the telephone call, the Provider's agent read back the wording of the complaint to the First Complainant to allow her to understand. The Provider's agent further set out the timeline for the complaint and the requirements for a final response letter from the Provider within 40 business days.

On **17 December 2019** to Provider send a letter of notification to the Complainant for the insurance period of **22 January 2020** to **21 February 2020**. This letter stated as follows

> "*It's time to renew your cover with Ireland's number one health insurer and we look forward to looking after your insurance needs for the coming year...*
> *The terms and conditions applicable to your policy is available in "My Policy"."*

The letter further added the following:

> "*IMPORTANT INFORMATION*
>
> - *We have based renewal on the plan you currently hold, or in the most recent information provided about your health insurance needs.*
> - *Please contact us if there have been any material changes in your circumstances or in your health insurance needs.*

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- *Please contact us before your renewal date to discuss your health insurance needs as we may have a more suitable plan for you.*
- *If you do not contact us prior to your renewal date your current plan will be renewed for further 1 year period.*

A material changes one which may impact your health insurance needs for the year ahead such as needing to add/remove someone from your policy, changing life stage or a change in your medical or financial circumstances."

On **17 December 2019**, the Provider also sent its final response letter regarding the complaint. In the table which set out the First Complainant's inpatient records in this letter, the Provider included the following:

Date	**Total In-Patient Days Billed**
26/11/2018 – 18/12/2018	22
11/11/2017 – 08/12/2017	27
19/11/2015 – 10/12/2015	21

On **23 December 2019**, the First Complainant telephoned the Provider regarding the final response letter of **17 December 2019**. During this call, the First Complainant stated that the **2013** and **2014** years were omitted from the table in the **17 December 2019** final response letter in the Provider's table. The First Complainant stated "*I would have spent a lot longer in hospital*" in **2013** and **2014**, "*approximately 80 odd days and 50 odd days*".

The Provider's agent checked with the Provider's records and stated that it was 50 days admission in **2013** between **13 June 2013** and **2 August 2013.** The Provider's agent then set out all the in-patient admission for psychiatric care for the First Complainant.

The Provider's agent then added up the total days for in-patient care which amounted to 68 days in total for **2013**. The Provider's agent then stated an extra 16 days of out-patient from **5 November 2013** to **12 March 2014**. Despite this being outpatient, the Provider's agent stated that this was included in the calculation for the 180 days for inpatient stays, under the policy. This meant the total days for **2013** would have been calculated as 84 by the Provider for **2013**. The Provider's agent then calculated 49 days inpatient for **2014**.

The Provider's agent during the call, stated that the letter of **17 December 2019** was the final response letter. When the First Complainants stated that the letter must actually "*say final response on it*" before it can be referred the matter to this Office, the Provider's agent stated that it is sufficient to state on the letter that the matter can be referred to this Office. The Provider's agent offered to send a new final response letter with "*Final Response Letter*" on it with the details of **2013** and **2014** as well. The Provider's agent again stated that there are still some plans with the 180 days cover and that "*there is never an intention to upset anyone*".

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The Provider sent a further response letter on **23 December 2019**. The content of this letter was nearly identical, the only difference being that the **23 December** letter contained some extra detail in the table which set out the First Complainant's inpatient records, and included the words "*Final Response letter*". The final response letter of **23 December** states as follows:

> "*I understand from your conversation with us on 11th November 2019 but you're unhappy regarding the upcoming reduction in psychiatric cover to 100 inpatient days under the [Provider's plan] level of cover from your next renewal date – 22nd January 2020.*
>
> *At the outset, I fully acknowledge your comments in relation to this matter and can assure you that it is never our intention to cause any frustration to our members. I would like to confirm that each renewal is for a period of 12 months and the benefits offered by a particular plan are subject to change at the following renewal date.*
>
> *[The Provider] is reducing the number of inpatient psychiatric days from 180 to 100 on a number of plans, as psychiatric care has moved away from in-patient based treatment. Psychiatric hospitals have evolved into offering day care and outpatient programmes, an overnight stay is not required, as well as community-based services such as the [a redacted community clinic].*
>
> *Following review of our records, I would like to clarify that your previous inpatient admissions have not exceeded 100 days per calendar year:*

Date	**Total In-Patient Days Billed**
26/11/2018 – 18/12/2018	22
11/11/2017 – 08/12/2017	27
19/11/2015 – 10/12/2015	21
17/11/2014 – 09/12/2014	5
09/06/2014 – 12/07/2014	44
05/11/2013 – 12/03/2014	16
13/06/2013 – 02/08/2013	50
20/05/2013 – 22/05/2013	2
01/05/2013 – 17/05/2013	16

> *It is important to note that treatment carried out on an outpatient basis for approved day care programmes is not deducted from the 180/1000 inpatient psychiatric days. While alternative plans are available that maintain 180 in-patient psychiatric days: I understand that in order to maintain other important aspects of your cover, an increase in premium would apply.*
>
> *I hope that this letter goes in some way to address in your comments. Should you wish to refer your complaints to the financial services and pensions ombudsman the contact details are as follows..."*

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On **2 January 2020**, the First Complainant submitted her complaint to this office. The First Complainant stated that upon learning that the Provider would be reducing her psychiatric cover from 180 days to 100 days for her policy in the upcoming renewal it caused her "*great stress and anxiety and I immediately telephoned the Provider and had a lengthy conversation with one of the agents*". She further added that she was unhappy with this phone call because to retain the 180 days cover she would have to increase her policy at a much greater expense from €3758.96 to €5003.84 to have joint cover with her husband (the Second Complainant). She added that the other alternative on offer was to reduce aspects of her policy like orthopaedic and ophthalmic cover and keep the 180 days of psychiatric in-patient cover.

The First Complainant stated that the first option was too expensive and she could not afford it and the second option meant losing out on two very important covers when arthritis and cataracts both run in her family.

The First Complainant stated that "*psychiatric cover is so important to me*". She submitted that she had been suffering from various mental health issues for the past eight years and had been hospitalised **in 2013, 2014, 2015, 2017** and **2018**.

The First Complainant stated she suffered from depression anxiety, stress, post-traumatic stress disorder (PTSD) and panic attacks and she required hospitalisation on occasions between 2013-2018 for "*intense treatment*" and could not have been treated as an outpatient or day care attendee, as suggested in the Provider's final response letter dated **23 December 2019**. She added that she has lost family members to suicide. She again stated that she would "*never know the day or hour when I might need to seek the help of*" the inpatient psychiatric hospital care. She also stated that her psychiatrist had advised her to make a formal complaint and that he also felt very aggrieved that she and some of his other patients "*are being pushed into this stressful situation simply because [the Provider] can change their policies whenever they feel like it*".

The First Complainant also submitted that she was out of work on long term sick leave and in receipt of half salary, which meant that an increase in premiums was an impossibility for her. She added that she understood that the Provider's policies are for a 12 month period and subject to change under its terms and conditions. However, she requested that this Office investigate such a drastic change of reducing psychiatric cover. She submitted she felt very prejudiced against, for having an illness that may require long term hospitalisation and she would feel under severe pressure if she were to be hospitalised again in the future as she would have to get better within a certain time frame before the 100 days of cover, ran out.

On **30 October 2020** the Provider submitted a response to this office. The Provider referred to rule 3A of the Rules terms and conditions of cover in respect of the First Complainant's policy which stated:

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> "*a) Your Policy will last for one year unless We agree to a shorter period. At the Renewal Date, the Policyholder can renew the policy by paying the premium We requested. The T&C's and Your Table of Benefits in place at the Renewal Date will then apply to the policy*."

The Provider has submitted that it is satisfied that it gave sufficient notice to the First Complainant that the benefits on her policy would be changing with effect from **22 January 2020**. It again refers to the email of **22 October 2019** which outlined that there would be a benefit change, and also to the policy renewal documents which were issued on **17 December 2019.**

The Provider has submitted that it complied with provisions 2.5 and 5.1 of the Consumer Protection Code 2012 (the 2012 Code). The Provider stated it carried out a "*fact find*" in respect of the First Complainant by seeking relevant information from her and posing a number of questions. It submitted that by gathering and recording the appropriate information from the First Complainant, its advisers were in a position to recommend a level of cover that would reflect her personal circumstances. It has submitted that the most appropriate level of cover was under a certain policy which was recommended by more than one adviser to the First Complainant. The Provider stated that it acknowledged that the First Complainant was not happy with the increase in premium in respect of this new policy recommended by the Provider.

In respect of the reduction of 180 days to 100 days, the Provider stated that in 2019 it completed a review of its mental health proposition. It stated that its cover was weighted towards inpatient cover, over cover for early intervention, community care and outpatient care. The Provider stated that:

> "*research has shown that there is an increasing move towards early intervention and outpatient care which ensures members are treated in the right care setting and results in better outcomes for the majority of people as it provides more support for managing their mental health outside of the inpatient hospital setting*."

The Provider submitted that, as a result, it made a decision to reduce the inpatient cover from 180 to 100 days for inpatient care for some of its plans and at the same time, it introduced a direct pay mental health therapy benefit and a 24/7 mental health support line. The Provider also stated that its position was aligned with "*industry development and international best practise*" regarding mental health care settings. The Provider stated that it was aware that some consumers will continue to require inpatient care but that the vast majority of members require less than 100 days per year which is also the case for the First Complainant.

The Provider also submitted that it came to its attention that some consumers had their psychiatric outpatient care incorrectly counted against the 100/180 days psychiatric inpatient care in respect of their policy. The Provider submitted that it contacted the affected consumers, however the First Complainant did not avail of any outpatient psychiatric care between **2013** and **2017** and therefore was not affected.

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The Provider submitted that there is no precedent set for the number of psychiatric days included on its hospital policies and, though they have reduced 180 days to benefit 100 days for some policies, consumers are free to choose a policy which has 180 days of psychiatric benefit. The Provider has also submitted that it does not believe it is morally and ethically wrong in reducing the psychiatric benefits on some of its policies.

In an email dated **5 November 2020** to this Office the First Complainant submitted that, contrary to the Provider's submission of **30 October 2020**, she did avail of day case treatment for psychiatric care and she provided dates in this regard, in the period of **2013** to **2018** which amounted to 22 days out-patient care.

In an email dated **17 November 2020** to this Office, the Provider in response to the First Complainants email again provided the full tables it had included in its final response letter of **17 December 2019** and its second final response letter **23 December 2019.** The Provider stated that the information contained in the **17 December 2019** letter was the same information that was provided in the **23 December 2019** letter, which also included years **2013** and **2014**. The Provider, however, acknowledged that 68 days treatment were allowed in **2013** and therefore it stated "*I would like to take this opportunity to correct our statement that the First Complainant did not exceed 50 days in any one year. All claims assessed were within the 180 days benefit as per the terms and conditions of cover*."

On **2 December 2020** the First Complainant made a submission to this Office which stated that the Provider's final response letter dated **23 December 2019** had stated that there were 203 total inpatient days billed, however, in the most recent breakdown of days included in the **1 December 2020** submission from the Provider, the total of days added up to either 168 days or 173 days depending on whether the Provider included the five days under the claim number 10382****.

The First Complainant stated that she was frustrated with the correspondence and the fact she had to "*go back with questions over inaccuracies on their part*". She also stated this was having an effect on her mental health.

On **14 December 2020** the Provider responded by way of submission to this Office, but again responded to the comments of the First Complainant from **2 December 2020**. The Provider outlined that in **2013** it was held for eight half days: in **2014** a total of 51 days: in **2015** a total of 21 days: in **2017** a total of 27 days: in **2018** a total of two days. I note that this calculation amounts to 101 days. Accordingly the addition of 68 days in **2013** and the two half days in 2013 (which amount to one day billed) comes to a total of 173 days. I note that the confusion appears to arise from the difference between the total amount of days put forward in the table in the final response letter of **23 December 2019** and the final submission to this Office stating **14 December 2020** from the Provider. The discrepancy of 203 days as against 173 days seems to be because initially in its final response letter the Provider included 22 total inpatient days billed in the **2018** period. However, this was reduced to two days in **2018** in its later submission dated **14 December 2020**. Accordingly, this may go some way towards explaining the confusion of the First Complainant.

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On **14 December 2020**, the First Complainant made a submission to this Office stating "*I'm afraid I have run out of steam and have no further comments to make. I'm not in a good place with my mental health currently and have no fight left in me to challenge yet again discrepancies in their response*."

Analysis

I note the following term of the First Complainant's policy:

> "*a) Your Policy will last for one year unless We agree to a shorter period. At the Renewal Date, the Policyholder can renew the policy by paying the premium We requested. The T&C's and Your Table of Benefits in place at the Renewal Date will then apply to the policy*."

I also note the Provider's submission that benefits for her specific plan were outlined prior to the First Complainant's renewal date and that it could not agree to apply the same benefits for an existing member and apply different benefits for a new member, stating that to comply with the consumer protection code, it is an imperative that all its members enjoy equal benefits for the same level of cover chosen. I note that the First Complainant in her complaint to this Office on **2 January 2020** stated she understood that the Provider's polices are for a 12 month period and subject to change under its terms and conditions. However, she requested that this Office investigate such a "*drastic change*" of reducing psychiatric cover.

I am satisfied that under the terms of the policy, the Provider was entitled to alter the benefits available under the Complainants' policy, at renewal time, when the 12 months of cover under the annual contract were ending, because in essence the renewal of the policy sees a new contract which will again last for 12 months. As a result, though I sympathise with the First Complainant, the Provider had no contractual obligation to maintain the cover at the same level from her policy renewal date, and it was open to it to reduce the amount of inpatient psychiatric days from 180 days to 100 on the policy.

I am satisfied that it was then up to the First Complainant to (i) seek health insurance cover elsewhere, (ii) decide to renew her policy on the basis of a reduced level of inpatient psychiatric cover, or (iii) change to a more expensive policy with the provider which covered 180 days of in-patient psychiatric care (which in her case would not have been an "upgrade" of in-patient psychiatric cover from what she had already held, but would unfortunately have been more expensive).

Provision 2.5 of the 2012 Code states that a Provider must seek from its customer's information relevant to the product or service requested. Provision 5.1 of the 2012 Code provides that:

> "*A regulated entity must gather and record sufficient information from the consumer prior to offering, recommending, arranging or providing a product or service appropriate to that consumer. The level of information gathered should be appropriate to the nature and complexity of the product or service being sought by the consumer, but must be to a level that allows the regulated entity to provide a professional service and must include details of the consumer's:*

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a) Needs and objectives including, where relevant:

i) the length of time for which the consumer wishes to hold a product,
ii) need for access to funds (including emergency funds),

iii) need for accumulation of funds.

b) Personal circumstances including, where relevant:

i) age,

ii) health,

iii) knowledge and experience of financial products,

iv) dependents,

v) employment status,

vi) known future changes to his/her circumstances".

Having reviewed the content of the calls between the Providers' agents and the First Complainant, and in particular the calls on **22 October 2019** and **4 November 2019**, I'm satisfied that the Provider complied with provision 2.5 and 5.1 of the 2012 Code. I note that the Provider's agents carefully took details from the First Complainant and were able to offer her a policy which would leave the Second Complainant's benefits the same, but change the First Complainants policy so that she would retain the 180 days in question. The Provider's agents also stated that there would be an increase in price for the First Complainant and set out the exact increase in the cost of the policy to the First Complainant. Provision 5.16 of the 2012 Code states that when assessing the suitability of a product, the Provider must consider if the consumer "*i) is likely to be able to meet the financial commitment associated with the product on an ongoing basis; ii) is financially able to bear any risks attaching to the product or service*;".

Although the First Complainant says that she was on long term sick leave and in receipt of half salary, I note that the Provider took this into account during the telephone calls, but unfortunately, any policy which took into account her requirement of 180 days for inpatient psychiatric cover, was going to see an increase in costs. Happily, the Complainant's medical needs over the last few years have not required psychiatric inpatient cover beyond 100 days, and it is to be hoped that she will continue to be covered as she needs, under her policy with the Provider.

In light of the entirety of the foregoing and bearing in mind all of the evidence put forward by the parties, in the absence of wrongdoing by the Provider regarding the contractual arrangement in place, I do not consider it appropriate to uphold this complaint.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

28 January 2022

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.