An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0099
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a private serious illness insurance policy with an insurance company (the "**Provider**").

The Complainant's Case

The Complainant says that on the **23 July 2019** she submitted a claim to the Provider under her serious illness insurance policy arising from her rheumatoid arthritis. The Complainant states that she was diagnosed with this illness in **October 2018** having displayed symptoms in **February 2018**. The Complainant states that she still has rheumatoid arthritis but "*on a more escalated level*." Complainant states that "*I have been born diagnosed with a condition that they cover*." The Complainant states that the Provider, by letter dated **16 December 2019,** refused her claim stating that it "*felt that I didn't meet their criteria definition in relation to their description of the condition one should be in to have their claim admitted*."

The Complainant asserts that her claim should be paid and she states that "*I live with chronic pain on a daily basis and I'm on a lot of medication and injections to keep the condition at bay.*"

The Complainant submits that her Consultant Rheumatologist wrote to the Provider to express

> *"his disgust in relation to the claim outcome because in his professional view I was well advanced in relation to having Rheumatoid arthritis as far as the definition goes in the professional field he works in*."

By letter dated **19 December 2019**, the Complainant's Representative submits that the Complainant has paid her premium for 7 / 8 years, that her diagnoses is professional and that her condition is seriously painful - "*the effect its having and in particular on her hands and joints is excruciating.*" The Complainant's Representative further asserts that "*I find it hard to believe that compared to the 'pain place' she is presently at that there seems to be another pain level she needs to go through to see this claim been paid*."

By letter dated **22 November 2019**, the Consultant Rheumatologist wrote the Provider and said as follows:

> *"My concern is that your definition of rheumatoid arthritis, which does not reflect any of the currently accepted international criteria for the diagnosis of rheumatoid arthritis, is overly restrictive. You require for the diagnosis of rheumatoid arthritis that all of your criteria be satisfied … you have two criteria that must be satisfied both of which are very rare for any patient to be diagnosed with rheumatoid arthritis*."

By letter dated **29 April 2021**, the Consultant Rheumatologist wrote the Provider and said as follows:

> *"I would state that the criteria are so strict as to be almost impossible to satisfy in a modern day Rheumatoid Arthritis patients. You are aware of their criteria but in particular they state that there "must be subcutaneous nodules'. These are actually very rare in Rheumatoid Arthritis. particularly these days with the therapies that are available. They further state that there must be joint destruction in order to make the diagnosis which again does occur in modern cohorts of patients but quite rarely thankfully due to therapy. They state that the patient must have stiffness in the morning for an hour which would be a feature in keeping with untreated Rheumatoid Arthritis, the patients when treated will normally have no stiffness but they may still have severe pain and loss of function*."

The Complainant's Representative also asks the Provider to "*look at the bigger picture here as to where my client's condition is at and where it will inevitably be down the road*." The Complainant submits that she "*has been very disappointed. frustrated and annoyed at the claim outcome.*" The Complainant wants the Provider to "*pay her claim*."

The Provider's Case

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The Provider submits that on **14 December 2018**, the Complainant's broker wrote to it attaching a letter from the Complainant's Consultant confirming that she had been diagnosed with Sero Negative Palindromic Rheumatoid Arthritis and that she was going through a flare up.

The Provider submits that in relation to standalone specified illness benefit, the **Policy Conditions** provided to the Complainant on **20 April 2012** confirmed that she would be provided with a lump sum amount if she was diagnosed *"with a Specified Illness as outlined in Appendix A during the term of Cover for this benefit*."

The Provider says that one of the specified illnesses covered in Appendix A of the **Policy Conditions** is *Rheumatoid Arthritis of specified severity*. The Provider obtained a private medical report from the Complainant's GP and one from her Consultant Rheumatologist.

The Provider, in its **Final Response Letter**, dated **22 January 2020**, states that, having contacted its Claims Department, that

> "*that they are unable to honour your claim as it does not fall within the definition for Rheumatoid Arthritis of specified severity which is outlined in the policy conditions that were issued to you upon commencement of this policy in April 2012*."

By letter dated **4 October 2019**, the Provider says its Chief Medical Officer reviewed the medical reports from the Complainant's GP and the Complainant's Consultant Rheumatologist and that consequently the Provider declined the claim noting as follows:

> "*We along with our Chief Medical Officer are satisfied that while there has been a definite diagnosis of Rheumatoid Arthritis, currently you do not meet the severity criteria. Dr* [name redacted] *has confirmed that both Rheumatoid Factor and CCP antibodies are negative, there is no evidence of subcutaneous nodules and there is no evidence of widespread joint destruction. We understand from the information also that the diagnosis and treatment have been less than 12 months. Regrettably there is no benefit payable at this time*."

The Provider asserts that:

> *"It is a positive development that medical advancements have had the effect of preventing or delaying [Complainant's] condition from progressing to a stage where subcutaneous nodules and radiographic changes develop but it does not alter the position that [Complainant's] condition when assessed did not meet the definition of 'Rheumatoid Arthritis of specified severity' as set out in her Policy conditions…*

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[Provider] is of the view that the definition of 'Rheumatoid Arthritis of specified severity' in the 2012 Policy conditions was an appropriate definition at the time, was capable of being met in 2012 and for some time after, it was aligned with comparable definitions in the market at the time, and that including the words 'of specified severity' made it clear that the cover would not extend to all cases of Rheumatoid Arthritis. [Provider] does not dispute that medical advancements may be such that it is harder to meet the definition of 'Rheumatoid Arthritis of specified severity' today than it was in 2012. Indeed taking account of medical advancements, the same cover is not available in similar policy conditions today. Policy conditions and definitions change over time to take account of medical advancements but the cover that applies in any one case is the cover as stated in the policy conditions that applied at the time a policy is taken out."

The Provider further asserts that:

"The cover was never intended to cover all diagnoses of Rheumatoid Arthritis and we believe this was made clear in the language used. We believe that most, if not all, insurers in the Irish market want to see some form of severity levels to demonstrate the claimant suffers severe chronic Rheumatoid Arthritis and [Provider] is not an outlier in this regard.... it should also be noted that the [Provider] had no obligation to use a specified national or international standard when developing its definition. When developing a definition, the [Provider] does however have regard to standards in general and to the advices of medical professionals to ensure a definition is capable of being met by lives insured with severe Rheumatoid Arthritis. The definition was developed in 2010 in conjunction with the [Provider's] medical experts, reinsurers and their medical experts and the definition has been met since 2012."

The Provider states that, due to a review some years prior, cover for Rheumatoid Arthritis of 'specified severity' was removed. By letter dated **16 December 2019**, the Provider says "*we do appreciate that your condition can deteriorate and we would be happy to review the claim again if you feel that the above definition can be met*."

The Complaint for Adjudication

The complaint is that the Provider has wrongfully repudiated the Complainant's claim for serious illness benefit under the policy.

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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 **22 February 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.

I note that the Provider's **Policy Conditions**, page 4, says as follows:

> "***Specified Illness***
> *A Specified Illness is the definite diagnosis by a Consultant of an Irish or United Kingdom Hospital and as verified by the Company's Chief Medical Officer, of the first occurrence of any of the illnesses outlined*
> *in Appendix A and/or Appendix B during the Term of Cover for the Accelerated or Standalone Specified Illness Benefit*."

The Provider's **Policy Conditions**, page 20, says as follows:

> "*39. Rheumatoid Arthritis – of specified severity*
>
> *A definite diagnosis of chronic rheumatoid arthritis by a consultant rheumatologist of an Irish or United Kingdom Hospital resulting in all of the following:*
> *the condition must be diagnosed, established and treated for a period of at least 12 months;*

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there must be morning stiffness in the affected joints of at least one-hour duration; there must be arthritis of at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a rheumatologist;
the arthritis must involve at least one or more of the following sites:

- *wrists or ankles;*
- *hands and fingers;*
- *feet and toes*

the arthritis must affect both sides of the body;
presence of rheumatoid factor or anti CCP (anticyclic citrullinated protein protein) antibodies, unless all other criteria are met;
there must be subcutaneous nodules (nodular swelling beneath the skin);
there must be radiographic changes typical of active rheumatoid arthritis."

The **Central Bank's Consumer Protection Code, 2012 (as amended) ("CPC")** is relevant and at Provisions 2.1 and 2.2, states as follows:

"*A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:*

2.1 acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;

2.2 acts with due skill, care and diligence in the best interests of its customers."

The **CPC** provides at paragraph 4.1 that:

"*4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information*."

Paragraph 4.37, says that:

"*4.37 Prior to a consumer completing a proposal form for a serious illness policy, a regulated entity must explain clearly to the consumer the restrictions, conditions and general exclusions that attach to that policy.*"

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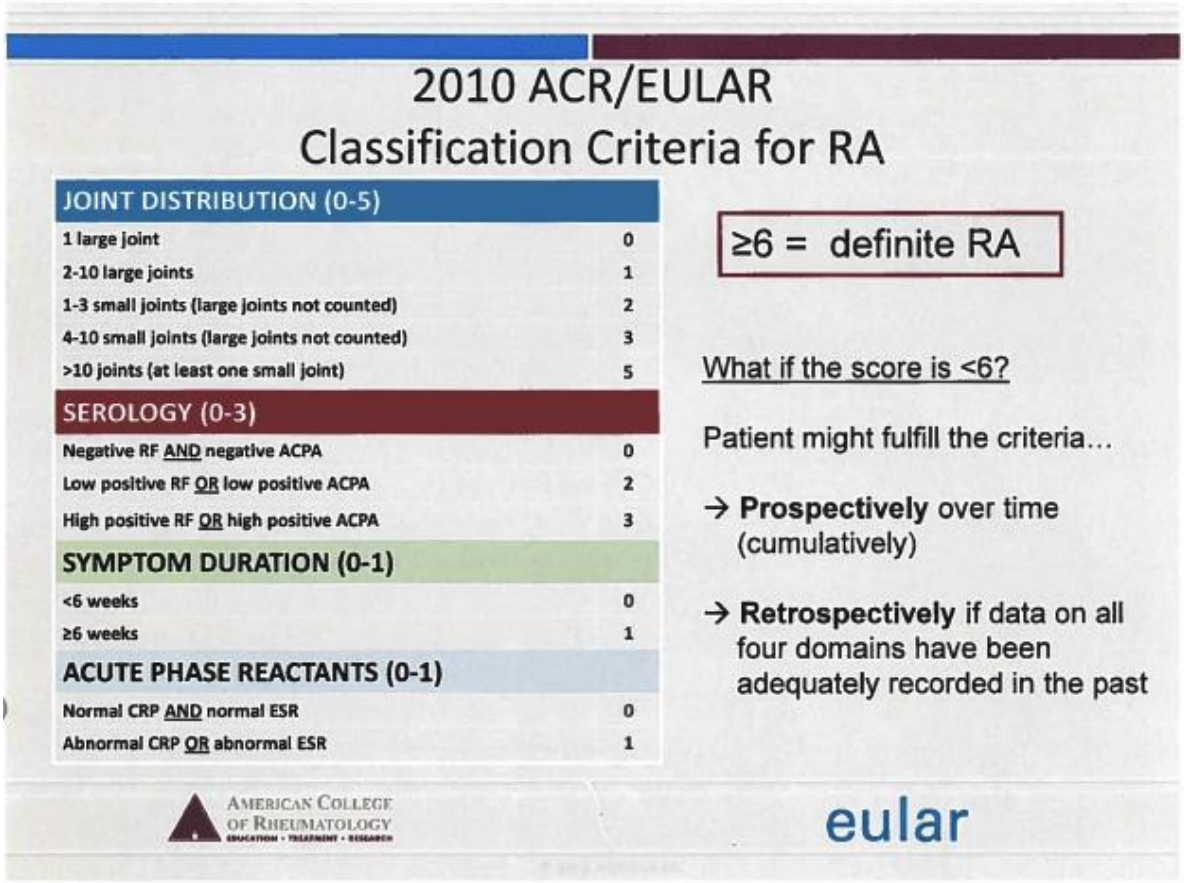
I note that by letter dated **29 April 2021**, the Complainant's Consultant Rheumatologist wrote to the Provider and said as follows:

> *"I attach a copy of the 2010 American College and European on Rheumatism criteria for the diagnosis of Rheumatoid Arthritis which are widely accepted internationally*."

I note the contents of the **2010 American College of Rheumatology/eular** (European League against Rheumatism) classification criteria for the diagnosis of Rheumatoid Arthritis as follows:



By letter dated **22 November 2019**, the Consultant Rheumatologist wrote to the Provider and said as follows:

> *"I am writing to you to ask you to correct these criteria. The criteria you require to be satisfied for a diagnosis of rheumatoid arthritis to be made are entirely a work of fiction and have no scientific basis. May I suggest you adopt the American College for Rheumatology (ACR) criteria as this would be the most widely accepted tool internationally*."

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By letter dated **16 December 2019**, the Provider write to the Consultant Rheumatologist and said as follows:

> *"we have taken on board your comments regarding the definitions we are currently assessing our Claimants under and have brought it to the attention of our Product Development team. We will look to improve future policies and offer a more meaningful definition in keeping with medical progressions. Unfortunately this is not something we can review under current policies …"*

By letter dated **30 January 2020**, the Consultant Rheumatologist wrote back to the Provider and sought an update on the matter for the Irish Society for Rheumatology spring meeting that year.

As to whether the Provider abided by Provision 4.1 of the CPC to ensure that *all information it provides to a consumer is clear, accurate, up to date, and written in plain English* with *key information must be brought to the attention of the consumer (without disguising, diminishing or obscuring important information)* and Provision 4.37 of the CPC, to *explain clearly to the consumer the restrictions, conditions and general exclusions* of the **Policy Conditions**, the Provider submits that:

> *"the Policy was sold to [the Complainant] by an independent broker. We are not in a position to comment on the discussions that took place at point of sale in relation to the Policy. We can however confirm that by signing the declarations associated with the application [Complainant] confirmed as follows: 'I confirm that where one of the following: Accelerated Specified Illness Benefit, Additional Specified Illness Benefit, Standalone Specified Illness Benefit, Surgery Payment, Accident Payment, Hospitalisation Payment, Broken Bones Payment has been selected that the restrictions, conditions, 'and exclusions that attach to the benefit(s) have been fully and clearly explained to me.'"*

The Provider also submits that:

> *"we can confirm that when the Policy went into force Policy documents were issued to [the Complainant]. The covering letter asked [Complainant] to consider the enclosed documents carefully to confirm that the Policy satisfied her needs. The Policy conditions set out in detail the terms and conditions associated with the Policy, including the definition that needs to be met for a claim for 'Rheumatoid Arthritis - of specified severity' to be admitted."*

I note that the Complainant does not complain that the policy was mis-sold to her or that important information was obscured. Rather, she is dissatisfied with the policy criteria to be met, and her representative maintains that the criteria are entirely outdated.

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I note that the Provider states that the policy was arranged through the Complainant's Broker and further asserts that it wrote to the Complainant on **20 April 2012** to enclose the Policy Schedule and conditions and an Important Information notice. I note the contents of this letter including the following wording –

> "I *am pleased to enclose your Policy Pack which comprises:*
>
> 1. *a copy of your* ***Policy Schedule*** *- which shows your policy details.*
>
> 2. *your* ***Policy Documents*** *- including your legal contract of assurance.*
>
> 3. *An* ***Important Information Notice*** *containing information about your policy. This includes a "cooling off" notice entitling you to cancel the policy within 30 days by instructing us in writing and returning the policy documents (including the Policy Schedule) to us.*
>
> *…*
>
> *You should study these documents carefully to ensure that the* [name of policy redacted] *meets with your requirements and is to your satisfaction. If you have any questions or if you need more information please contact…"*

I am satisfied that all information provided to the Complainant was clear, accurate, up to date, and written in plain English with key information brought to her attention and that she confirmed that she had the benefit of her Broker explaining to her the restrictions, conditions and general exclusions of the policy. As result, I am satisfied that the Provider met its obligations pursuant to Provisions 4.1 and 4.37 of the CPC.

I have considered whether it was reasonable for the Provider to refuse the Complainant's claim under the **Policy Conditions** and whether the Provider acted in accordance with its obligations under 2.1 and 2.2 of the CPC to act "*honestly, fairly and professionally in the best interests of its customers* and with *due skill, care and diligence"*. I note the very specific criteria laid out by the Provider for covering severe forms of rheumatoid arthritis. I note the contents of the **Claim Form** dated **23 July 2019** which states that the Complainant has "*severe pains in hands and feet (both) – coupled with severe stiffness and swelling in both hands and feet*."

This **Claim Form** notes the Complainant's medications include injections, regular bloods, physical exams, x-rays and that she is taking Methotrexate, Deltacortril and folic acid. In particular, I note that the **Specialist Medical Report – Chronic Rheumatoid Arthritis,** dated **18 September 2019,** says that symptoms have been present since late 2017, that there is swelling in joints of the hands and feet, that morning stiffness of at least an hour's duration has been reported, that there is no evidence of subcutaneous nodules and that the arthritis affects both sides of the body. Tests for Rheumatoid factor and CCP antibodies were negative.

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I note that an assessment of the **Claim Form** and the **Specialist Medical Report – Chronic Rheumatoid Arthritis** makes it clear that the Complainant did not meet the criteria laid down in the Terms and Conditions of the policy. In particular she did not have subcutaneous nodules or the presence of rheumatoid factor or anti-CCP.

I note the various medical submissions including references by medical professionals to international standards. I note the submissions by the Consultant Rheumatologist that the Provider's Definition "*does not reflect any of the currently accepted international criteria for the diagnosis of rheumatoid arthritis*" and is "*overly restrictive*." I also note the Consultant Rheumatologist's point that "*the criteria are so strict as to be almost impossible to satisfy."*

The essence of these submissions is that improvements in treatment over time, may eliminate certain symptoms and that this may change the relevant criteria to describe a disease. The Provider says however that it "*had no obligation to use a specified national or international standard when developing its definition"* and that the definition was an "*appropriate definition at the time*", appropriate to "*comparable definitions in the market at the time*."

I am satisfied on the evidence before me that when the Complainant made a claim to the Provider seeking payment of benefit under her policy terms and conditions, arising from her diagnosis of rheumatoid arthritis, the Provider was entitled to assess her claim against the specific policy criteria which had been agreed between the parties in 2012. I note in that regard that the policy definition makes clear that the illness in respect of which specified illness benefit will be paid, is identified as "*Rheumatoid Arthritis – of specified severity*". I am satisfied that the title of this illness warned proposers for insurance and policyholders that a very specific severity of Rheumatoid Arthritis would be required, in order to meet the criteria for payment of benefit. Those criteria are very specifically laid out within the policy terms and conditions, and this is the basis upon which the parties insurance contract was entered into.

The Complainant's grievance is that because medical treatments have improved in the years since she entered into her insurance policy with the Provider, the criterial laid down within the policy provisions will be satisfied only in a limited number of cases and those criteria are difficult to meet, from a practical point of view, even though the symptoms she is experiencing are of a significant severity.

I note that the Provider does not disagree that the medical situation has evolved in the decade since the Complainant entered into her policy with the Provider. I am satisfied however, that when the Complainant made her claim to the Provider, the Provider was entitled to assess that claim by reference to the specific policy provisions which were in place between the parties, whether or not the policy definitions and criteria have been revised in more recent times for newer specified illness policies coming into existence for other policyholders.

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Accordingly, whilst I am conscious that this decision will be disappointing to the Complainant, nevertheless I am satisfied that there is no evidence of wrongdoing by the Provider in its assessment of the Complainant's claim and for that reason, 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
Financial Services and Pensions Ombudsman (Acting)

21 March 2022

PUBLICATION

Complaints about the conduct of financial service providers

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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension providers in such a manner that—

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(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.