An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0128
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Claim handling delays or issues Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a private health insurance policy that the Complainant holds with the Provider. The initial complaint was that the Provider had wrongfully declined the Complainant's claims and that it failed to deal with the complaint in a timely manner. During this Office's investigation, the Provider decided to accept the Complainant's claim after new information which was submitted "*clarified*" the matter. Following this, the Complainant's Representative states she wishes to have the matter progressed to adjudication as he contends the Provider unnecessarily prolonged the process.

The Complainant's Case

The Complainant is represented by his daughter in respect of the complaint (the Complainant's Representative).

The Complainant's Representative submits that in **June 2014** the Complainant had contacted the Provider to discuss a cheaper plan option and that, as a result of this discussion, the Complainant's policy was downgraded on **1 July 2014** to a less expensive policy that contained fewer benefits than the previous policy which he held with it.

The Complainant's Representative submits that in **June 2016** she discovered, through discussions with the Complainant, that he had downgraded the health insurance policy in **2014**. The Complainant's Representative submits that upon hearing this information she immediately contacted the Provider on the Complainant's behalf and that as a result of this discussion with the Provider, the Complainant's policy was upgraded on **17 June 2016**.

The Complainant's Representative submits that towards the end of **2016** the Complainant became ill and on **2 December 2016** he attended the accident and emergency department (A & E) of a private hospital for treatment where he remained as a patient until **16 December 2016** to undergo tests, to confirm a diagnosis. The Complainant was readmitted to the private hospital on **2 January 2017.**

The Complainant's Representative submits that, prior to the Complainant presenting to the private hospital on **2 December 2016**, she had contacted the Provider to check the Complainant's level of cover under the policy and the Provider informed her at the time that the policy included cover for that particular hospital.

The Complainant's Representative submits that, following a week of tests in hospital, the Complainant was diagnosed with compression of the nerves in his cervical spine. The Complainant's Representative states that the Complainant was hospitalised again from **2 January 2017** to **13 February 2017** at the same private hospital at which he underwent surgery for his condition.

The Complainant's Representative states that in **June 2017** the Provider informed the Complainant that the treatments that had taken place in the private hospital between **December 2016** and **February 2017** were not covered under the policy.

The Complainant's Representative submits that at the time of upgrading the policy on **17 June 2016**, the Complainant was in good health and did not suffer any signs of the medical problems that caused him to attend the private hospital on **2 December 2016** and **2 January 2017.**

The Complainant's Representative submits that the Complainant's spine surgeon, Dr A, wrote to the Provider on **18 May 2020** stating that the Complainant was treated for myelopathy in **December 2016** and early **2017** and not cervical stenosis as described by the Provider in its declinature letter. Dr A submits within the medical letter dated **18 May 2020** that myelopathy is a new diagnosis and not a pre-existing condition. Dr A also referred to an earlier medical report of Dr S dated **13 March 2013**, who was the Complainant's previous consultant. Dr A states that, while an MRI scan that the Complainant underwent for his spine in **2013** showed some evidence of cervical stenosis, in his medical opinion that the Complainant did not appear to have any difficulty with fine motor function, other than mild gait disturbance. Dr A says that Dr S:

> "*therefore did not feel that [the Complainant] had myelopathy and therefore did not feel that surgery was indicated. Therefore there was not a diagnosis of myelopathy made at that stage*."

The Complainant's Representative states that his symptoms came upon him very suddenly prior to his attendance to A&E on **2 December 2016** and it was not known by the medical staff at the time, what was the cause of the Complainant's symptoms. The Complainant's Representative asserts that it was not until one week into the Complainant's admission in hospital that he was subsequently diagnosed with compression of the spine. She further submits that had she or the Complainant, known that the policy did not cover for the

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treatments at the private hospital, he would not have presented to the particular hospital on either occasion in **2016** or **2017**. The Complainant's Representative submits that she had contacted the Provider before the Complainant attended the A & E Private Hospital on **2 December 2016** to confirm if the treatment would be covered under the policy. She submits that the Provider confirmed at that time, and on other occasions, that treatment would be covered under the policy.

The Complainant's Representative submits the Provider delayed in its response to the complaint pertaining to the declinature of the claims and that it issued its final response letter on **5 June 2018**, which she submits was almost one year after the complaint had been submitted. On **24 November 2020** the Provider, following a letter from Dr S, and the subsequent review by its medical advisors, decided to pay the claims. The Complainant's Representative submits that, despite the claims now being paid, she believes that the Provider failed to consider her submissions that she had made to it. She states that the Provider should have clarified regarding the pre-existing condition with Dr A, Dr S and the treating doctors.

She states that this matter could have been resolved at an earlier stage and the Complainant would not have had to endure such hardship and stress over the last four years. She adds that her father was completely overwhelmed and was not in a fit state to communicate with the various parties involved. She submits that the Provider did not adequately investigate this matter and had unnecessarily prolonged the process. It was not until she had contacted the Complainant's treating doctors and provided their reports for this process, that their medical opinions were even considered by the Provider.

The Provider's Case

In the Provider's final response letter dated **5 June 2018**, it states that the claims were declined because the information provided indicated that the cervical stenosis which prompted these admissions was present prior to the Complainant increasing his benefits to include cover for the private hospital on **17 June 2016**. The Provider states because he was serving a two-year upgrade waiting period, his claims were assessed in accordance with the previous scheme which did not provide cover for the private hospital in question. The final response letter stated that after the initial declinature was appealed, the Provider sought further clinical details documenting the Complainant's symptoms of cervical stenosis.

The Providers states that its external medical Advisory Board assessed the information and determined that the patient was operated on in **January 2017** for cervical spinal stenosis. The symptoms the surgery was based on were upper arm weakness and mild weakness bilateral in the legs, for which he was admitted to hospital in **December 2016**. However, similar but minor symptoms were presented already in at least **February 2013**. These the symptoms of tired legs while walking (weakness), paraesthesia of both hands, spondylosis were described already in **2008**. Therefore, signs of cervical spondylosis were known since **2008** and symptoms of cervical Spondylosis with spinal stenosis was known since at least **February 2013**.

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The Provider referred to page 44 of the policy document which states as follows:

> "*In addition, if you're upgrading your level of cover/benefits the following waiting periods will apply regardless of how long you have been insured:*
>
> *You have health insurance and want to get a higher level of cover/benefits, how long before you can avail of better cover/benefits for any disease, illness or injury which began or the symptoms of which began before you upgrade it?... 2 years for all age groups*"

The Provider refers to the definition of "Pre-existing condition" at page 5 of the policy:

> *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. or*
> c) *The day you changed your scheme and gained additional cover/benefit.*
>
> *Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final*."

The Provider submits that the Complainant was serving a two year upgrade rule for cover in the private hospital, at the time of these claims which was not due to expire until **17 June 2018**. Therefore, any admission to a hospital where the Complainant did not previously have cover would incur a two-year waiting period for any pre-existing conditions. The Provider states that based on the recommendation of its medical Advisory Board it was unable to consider the claims for benefit in line with the upgrade waiting period.

The Provider acknowledges receiving a letter from Dr S dated **11 November 2020** which stated that when the Complainant attended him in **2013,** he had cervical spondylosis but not cervical myelopathy. Dr S stated that it appeared that the Complainant subsequently developed cervical myelopathy which necessitated surgery and this was clearly documented in his notes, namely, that he did not have cervical myelopathy on the initial presentation. Dr S states that it is clear that his myelopathy, which is the condition that necessitated surgery, was new in onset.

After having its medical advisors review Dr S' letter, the Provider agreed to pay the two claims made by the Complainant. The Provider states that it sought clinical information from the various doctors including Dr S between **October 2017** and **June 2018.** Based on the clinical information that was available to it at the time, the Provider deemed it a pre- existing condition and so the claims were rejected.

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The Provider states that the letter received from Dr S explicitly clarified that it was cervical myelopathy that necessitated the Complainant's surgery. The Provider states that once this was explicitly stated, it became apparent that the claims need to be re-evaluated in light of the relationship to cervical myelopathy. The Provider adds that while it appreciates the Complainant is not happy with the length of time it took to settle these claims, these claims were at all times dealt with in the speediest possible time frame, given the clinical information that was available to the Provider.

The Complaint for Adjudication

The complaint is that the Provider did not adequately investigate the claim and unnecessarily prolonged the process.

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 **15 March 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 the telephone call on **17 June 2016**, where the Provider's agent stated to the Complainant's Representative that:

> "*because they're gaining something, for any pre-existing symptoms they have, there is a 2 year upgrade rule…for anything pre-existing it's two years.*"

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She added that new symptoms are covered straight away. I also note that a separate agent of the Provider again reiterated during a telephone call that same day, the two year upgrade rule for pre-existing conditions.

On **2 December 2016**, a Provider agent spoke to the Complainant on the telephone and stated that he would only be covered for "*a new condition*" and that he was serving a two year upgrade for any pre-existing for the private hospital. On the same day, an agent of the private hospital telephoned the Provider. The Provider's agent stated that if the treatment was for a pre-existing issue he would not be covered. The agent of the private hospital stated that it was "*new onset*" symptoms.

On **12 December 2016**, the Complainant's Representative telephoned the Provider to enquire whether the Complainant was covered in the private hospital. The Provider's agent stated that it "*would have to be a new symptom*" due to the two-year upgrade rule for pre-existing rule. The Complainant's Representative stated that it was a new symptom. On **13 December 2016,** the Complainant's Representative again telephoned the Provider asking whether the Complainant would be covered for surgery in the private hospital. The Provider's agent asked whether this was a new condition, stating that if it is a pre-existing condition, then he "*won't be covered*".

On **6 February 2017**, the Complainant's Representative telephoned the Provider. The Provider's agent stated that the Provider would take into account the Consultant's advices on the day, on whether the condition was pre-existing.

Accordingly, having considered the content of these telephone calls, I am satisfied that the Provider adequately communicated repeatedly that the Complainant would only be covered if the treatment was for a new condition.

There were two claims, the first for the hospital admission from **2** to **12 December 2016** (Claim 1). The second claim was for the hospital admission from **2 January 2017** to **13 February 2017** (Claim 2). Both Claims were rejected by the provider on **12 June 2017**.

I note that following from the policy regarding pre-existing injury:

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

I accept that under the terms of the policy, it is the Provider's medical advisors who determine whether the condition is pre-existing the policy upgrade. The Provider submits that after its internal medical advisors had reviewed the medical notes, and in particular, the letter of Dr S dated **13 February 2013,** it had a separate medical advisory board undertake a review of the matter. It states that these reviews advised that the Complainant's condition could not have developed to such a degree in the six-month period after the Complainant upgraded his cover to include the private hospital.

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Accordingly, I am satisfied that Provider was entitled under the terms of the policy to refuse the cover based upon the views of the medical advisors. I am pleased to note however, that the Provider remained open to changing its position and it did so in **November 2020** when new medical information was provided by Dr S which was material to clarifying the issue surrounding whether the condition was pre-existing.

The Complainant is unhappy and says that the Provider did not adequately investigate the claims and unnecessarily prolonged the process of admitting the claims for payment. In this regard, I note that Claim 1 form was received on **2 February 2017**. Claim 2 form was received on **4 April 2017**. Both claims were rejected on **12 June 2017**. After an appeal, the final response letter issued was dated **5 June 2018**.

I note that an agent of the Provider, as part of its assessment of the claim, sent a letter to Dr S on **31 January 2018** seeking "*complete consultation notes and documenting the symptoms of weakness, pain in both hands, numbness, pins and needles and loss of power*". Dr S replied on **1 February 2018** asking whether the Provider wanted copies of the **2013** correspondence.

On **27 February 2018**, another agent of the Provider sent an identical letter to Dr S seeking "*complete consultation notes and documenting the symptoms of weakness, pain in both hands, numbness, pins and needles and loss of power*". The letter of **27 February 2018** did not appear to acknowledge the letter from Dr S dated **1 February 2018** and was simply a reiteration of the **January 2018** request. Dr S replied on **13 March 2018** again querying whether the Provider required the **2013** notes. On **24 April 2018**, a third agent of the Provider responded by confirming that it required the **2013** notes and these were sent by the Dr S on **2 May 2018**.

I note the Provider expressly relied on Dr S's notes from **2013**, quoting its medical advisory board in its final response letter which stated: "*However, similar but minor symptoms were presented already in at least **February 2013***".

The reference to **February 2013** comes from the letter of Dr S dated **13 February 2013**, which specifically mentioned seeing the Complainant on **12 February 2013**. Notwithstanding the importance it placed on the **2013** notes of Dr S, the Provider delayed matters by failing to simply answer his query on **1 February 2018** regarding whether it required the **2013** notes. By the time the Provider answered his request, it was **24 April 2018**, nearly three months after his initial letter. Dr S was able to swiftly provide the **2013** documents within a week turnaround, so he did not delay providing the documents in any way. Therefore, the Provider delayed matters by nearly three months, by failing to respond to Dr S' query in February 2018.

Having considered the entirety of the matter however, I am satisfied that the Provider's approach to the assessment of this claim was a generous one. Although there was a delay in early 2018, details of which are outlined above, I note that the Provider adopted a generous approach to its assessment of the Complainant's symptoms of weakness, pain, pins and needles and loss of power and ultimately agreed in **2020** to admit both claims for payment.

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In all of those circumstances, I do not consider it appropriate to make any direction regarding the delay of 3 months in early 2018, in the course of the original assessment of the claims and I am pleased to note that the claims have been paid, as the value of those claims would otherwise have placed a very significant financial burden on the Complainant.

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)

11 April 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.