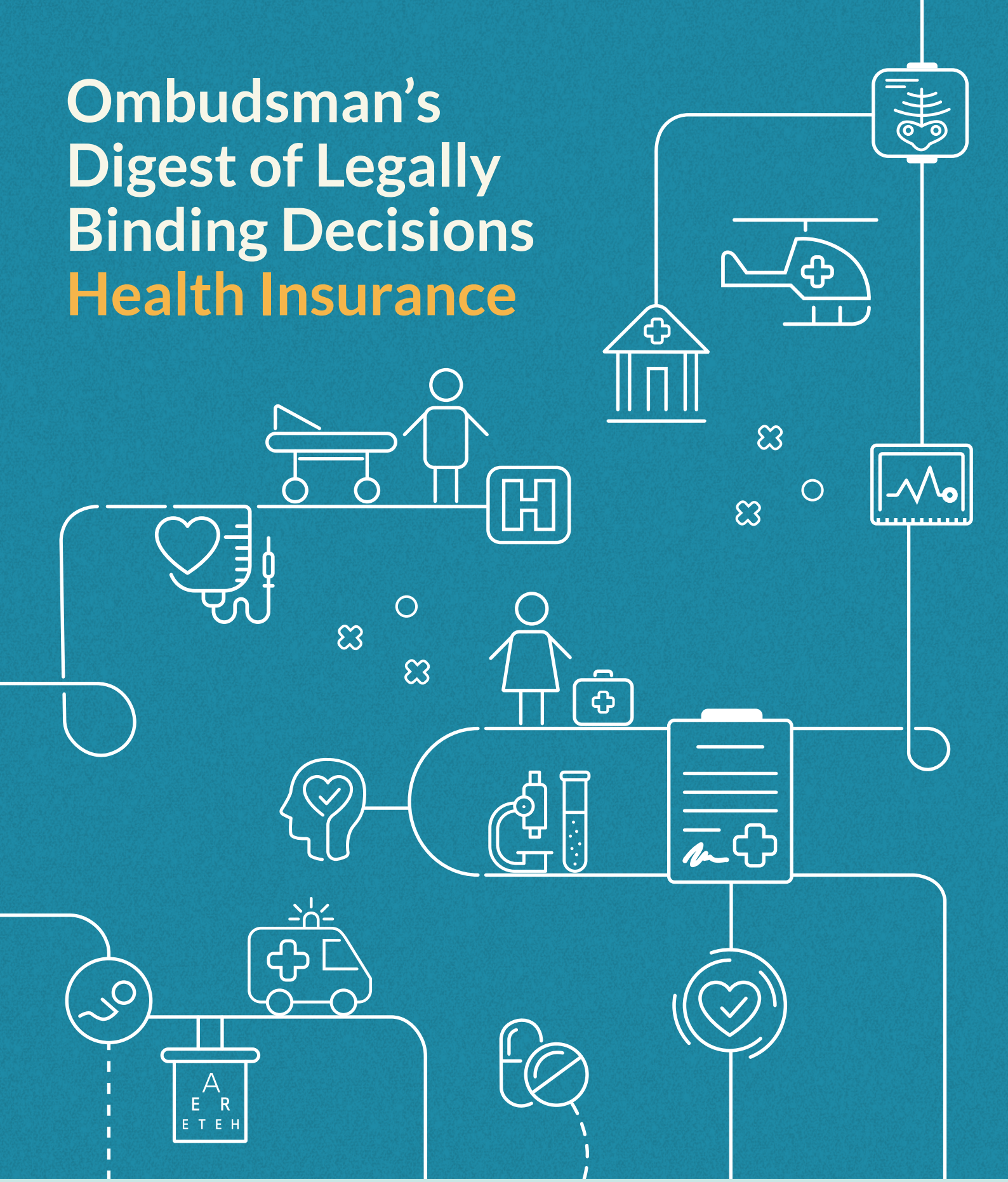
Ombudsman's Digest of Legally Binding Decisions

Health Insurance



Volume 8 | Published November 2022

Themed Digest of Decisions featuring legally binding decisions on complaints concerning health insurance.

An tOmbudsman Seirbhísí Airgeadais agus Pinsean

Financial Services and Pensions Ombudsman

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The Financial Services and Pensions Ombudsman (FSPO)

The role of the FSPO is to resolve complaints from consumers, including small businesses and other organisations, against financial service providers and pension providers.

We provide an independent, fair, impartial, confidential and free service to resolve complaints through either informal mediation, leading to a potential settlement agreed between the parties, or formal investigation and adjudication, leading to a legally binding decision.

When any consumer, whether an individual, a small business or an organisation, is unable to resolve a complaint or dispute with a financial service provider or a pension provider, they can refer their complaint to the FSPO.

We deal with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both parties. Much of this informal engagement takes place by telephone.

Where these early interventions do not resolve the dispute, the FSPO formally investigates the complaint and issues a decision that is legally binding on both parties, subject only to an appeal to the High Court.

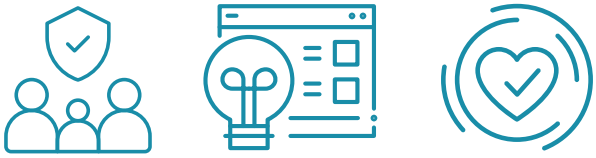
The Ombudsman has wide-ranging powers to deal with complaints against financial service providers and can direct a provider to rectify the conduct that is the subject of the complaint. There is no limit to the value of the rectification that can be directed. The Ombudsman can also direct a provider to pay compensation to a complainant of up to €500,000. In addition, the Ombudsman can publish anonymised decisions and can also publish the names of any financial service provider that has had at least three complaints against it upheld, substantially upheld, or partially upheld in a year.

When dealing with complaints against pension providers, the Ombudsman's powers are more limited. While the Ombudsman can direct rectification, the legislation governing the FSPO sets out that such rectification shall not exceed any actual loss of benefit under the pension scheme concerned.

Furthermore, the Ombudsman cannot direct a pension provider to pay compensation. The Ombudsman can only publish case studies in relation to pension decisions (not the full decision), and cannot publish the name of a pension provider, irrespective of the number of complaints it may have had upheld, substantially upheld, or partially upheld against it in a year.

Formal investigation of a complaint by the FSPO is a detailed, fair and impartial process carried out in accordance with fair procedures. For this reason, documentary and audio evidence and other material, together with submissions from the parties, is gathered by the FSPO from those involved in the dispute and exchanged between the parties.

Unless a decision is appealed to the High Court, the financial service provider or pension provider must implement any direction given by the Ombudsman in a legally binding decision. Decisions appealed to the High Court are not published while they are the subject of an appeal.



Message from the Ombudsman

We are approaching the time of year when many people will be looking ahead to 2023 and thinking about reviewing or renewing their private health insurance, or indeed perhaps switching providers, particularly in light of the current cost of living pressures.

This Digest of Decisions features decisions made by the FSPO in complaints concerning private health insurance. The Digest highlights the types of complaints we receive about private health insurance and some of the issues which are consistently raised with this Office by health insurance scheme members.

By publishing our full decisions in our decisions database on www.fspo.ie and summaries of our decisions in our Digest of Decisions, we aim to assist consumers, financial service providers and stakeholder groups in understanding the types of complaints made to the FSPO and the outcomes of some of those complaints. Importantly, these decisions can also demonstrate how some complaints might have been prevented.

The decisions in this Digest highlight the difficult circumstances experienced by customers which lead to a complaint to this Office. Issues surrounding health insurance are often fraught with additional worry and stress, very often during a period when the people involved can be feeling very unwell.

Private health insurance in Ireland

Recent market research carried out on behalf of the FSPO showed that 51% of our survey participants held private health insurance[1]. According to the Health Insurance Authority's Quarterly Report on Health Insurance for Q2 2022, the average premium per adult is €1,410 per year, which represents a significant amount from a household budget. This insurance, however, provides peace of mind to many, by providing supplementary access to both public and private hospitals, and outpatient care, to limit the financial impact of the cost of medical treatment that may be required. The level of hospital cover and outpatient cover is at all times determined by the type of plan chosen by the customer. With more than 300 different plan options available, there is tremendous choice in the health insurance market, but it can be a challenge to select the best level of cover to suit individual needs.

1 Data provided from a nationally representative sample of 1,006 adults aged 15+, undertaken by Ipsos on behalf of the FSPO in October 2022.

Waiting periods

In many of the complaints submitted to this Office, we can see a clear misunderstanding of how waiting periods operate. There is often confusion relating to the waiting period for pre-existing conditions, whereby a new customer is not covered for 5 years, for the cost of treatment for any condition, the signs or symptoms of which existed in the 6 months prior to taking out the health insurance plan, regardless of whether or not the customer was aware of this condition. People can have a very optimistic understanding of their own health, and we often see complaints where medical investigations, X-rays or blood tests, were required in the lead up to the policy being taken out, but the person involved does not believe that they had a pre-existing condition, because they had not been diagnosed or their medical issue had not been given a name. It is important for consumers to understand that a pre-existing condition can exist, without a formal diagnosis, and it is the signs and symptoms within the period, which are relevant.

In addition to the waiting period for new customers, when a customer upgrades their level of cover under a plan, there is a 2-year waiting period before that customer can access the higher hospital cover on the new plan for any pre-existing conditions.

The complexity around waiting periods can impact the ability of consumers to understand their health insurance cover and can lead to disappointment and frustration when claims are not paid.

For example, decision 2018-0044 concerned Matthew, who was diagnosed with prostate cancer in April 2016. Having upgraded his policy cover in January 2016, Matthew was subject to a 2-year waiting period to be covered for the higher benefits on the new plan, for any condition that already existed before the upgrade. Matthew thought that since he was diagnosed following the upgrade, his condition would not be considered pre-existing. However, diagnostic examinations had been carried out in October 2015, which showed the existence of the condition, thereby classifying it as pre-existing. The complaint was not upheld.

We also received a complaint from Sarah (decision 2019-0043), who suffered from Polycystic Ovary Syndrome (PCOS), which led to an irregular menstrual cycle. As a new customer who had taken out a policy in August 2020, Sarah was subject to the 5-year pre-existing condition waiting period. Sarah was diagnosed with a dermoid cyst in April 2021, which required surgery. She was advised by her gynecologist that it was a new diagnosis, entirely independent from PCOS. When Sarah enquired with her health insurer if she would be covered for the surgery, her insurer advised that if the onset date of the condition, was deemed to be prior to her taking out cover, she would not be covered.

Following Sarah's surgery in July 2021, her insurer declined to cover the costs of the surgery, on the basis that it was Sarah's symptoms (being her irregular menstrual cycle) which prompted the ultrasound and these symptoms had existed in the six months prior to Sarah taking out the policy. She was therefore subject to the five-year pre-existing condition waiting period, before cover would be available under the policy for that condition. As a result, the complaint was not upheld.

A similar complaint arose from Clara, who underwent surgery for a tumour in her back (decision 2020-0189). She took out private health insurance in January 2019, at which point she received a welcome pack and rules booklet which explained the waiting periods for pre-existing conditions. She went to the doctor the following day and explained she had been experiencing back pain for the last few months. The results of a scan showed a tumour in her back. Clara underwent surgery in March 2019, and the insurer refused to cover the claim on the basis that the signs and symptoms which led to Clara's diagnosis existed before Clara took out the policy on 5 January 2019. Whilst the Ombudsman's decision acknowledged that Clara was unaware of the tumour in her back, the complaint was not upheld, as the symptoms of her condition that required the surgical treatment, were present before the inception of the policy.

Level of cover on policy

It is important to be aware when buying an insurance policy of any kind, that there will always be limits to the cover and policies will not provide cover for every eventuality. Sometimes a health insurance policy will have limits to the number of treatments covered, the hospitals where treatment will be covered, or on the specific type of treatment or procedure covered.

Our recent research highlights that 27% of individuals surveyed[2] indicated they had a poor understanding of what their health insurance policy covered, so it is very important to always check your cover with your health insurer, before proceeding with any treatment or procedure, so that you can be clear on what procedures and what hospitals, the policy will cover.

2 Data provided from a nationally representative sample of 1,006 adults aged 15+, undertaken by Ipsos on behalf of the FSPO in October 2022.

An issue arose with limits on cover in a complaint received from Alanna (decision 2021-0379). She complained to the FSPO because her second claim for plasma treatment to relieve back pain, was refused. She required three sessions in a 6-month period. Alanna's insurer paid for the first round of treatment but refused to cover the second one, as Alanna's policy only provided for one such procedure to be covered within a six-month period. In an effort to help, the insurer advised Alanna's partner John, during a phone call, that pre-authorisation could be sought from Alanna's consultant to have additional cover approved, by submitting medical reasons behind the recommendation for the repeat procedure to be carried out. However, this pre-authorisation was not sought from Alanna's consultant and the claim was refused. The Ombudsman did not uphold Alanna's complaint as the insurer's reason for refusing the claim, i.e., that no details of the medical reasons for the repeat procedure so soon after the first, were received by the insurer. As pre-authorisation was not sought, the Ombudsman accepted that the position of the insurer was fair.

There can be times when the customer makes sure to check their policy cover but is not given accurate information by their insurer, such was the case with Alice (decision 2019-0416). Alice rang her health insurer to check her dental cover. Alice was advised that her insurance would cover 70% of the cost of one bridge and 70% of the costs of crowns up to a maximum of €600. However, five days after this call, Alice's policy was renewed and some of the terms of her policy changed, including a limitation on the amount that could be claimed for bridges. Alice was not advised of these pending changes during her call with the insurer. Alice underwent the dental treatment and expected to be reimbursed €3,000. However, the insurer only paid out €1,500 because of the new reduced benefit change and, worse again, it paid that money to an incorrect account.

The insurer maintained that its advice was correct at the time of the phone call but acknowledged its error in paying the claim to the wrong account. The Ombudsman found that it was unfair and misleading that Alice was not informed during her phone call with the insurance company querying her level of cover, that the relevant section of the table of benefits was due to change imminently. The Ombudsman substantially upheld the complaint and directed the insurer to pay €3,000 in compensation to Alice for the loss, expense, and inconvenience caused.

Pre-approval

Another aspect of private health insurance is the requirement to get pre-approval for procedures to be undertaken abroad. Pre-approval is necessary to ensure that the insurer can be satisfied that the treatment to be undertaken meets its criteria for approval. We sometimes see complaints arise where the customer does not understand this process and either doesn't get the required evidence for pre-approval, or gets the treatment anyway without approval, leading to a rejected claim. This obviously leads to great upset and stress for the customer at a time when they are already unwell and feeling vulnerable.

Two decisions summarised in this Digest highlight complaints that arose around this process.

Debbie applied to her insurer in January 2015 to be covered for treatment in another EU country (decision 2021-0027). Debbie had an aggressive illness which she described as leaving her totally disabled and she confirmed that since her treatment, her symptoms had receded. The total cost of the treatment came to €67,778.03, but her claim was refused by her insurer on the basis such treatment was 'experimental'. During the investigation of the complaint, the Ombudsman noted that it was remarkable that despite the minutes of the insurer's medical advice group making no reference to the "experimental" nature of the treatment, the insurer's decision stated that the treatment requested by Debbie was "experimental" and it used the absence of any long-term study as a reason for denying the claim. A detailed investigation of the claim was only submitted following Debbie's complaint to the FSPO. The Ombudsman upheld Debbie's complaint, concluding that the insurer arrived at its decision in an unacceptable and unjust manner and further noted that the three-and-a-half-month delay in communicating its decision to Debbie was extremely poor. The insurer was directed to pay the claim and pay the sum of €2,000 in compensation to Debbie for the inconvenience caused.

The second complaint in this Digest concerning pre-approval (decision 2021-0433), relates to Sylvia's daughter, Ella, who underwent surgery for scoliosis in another European country, as the only form of treatment available in Ireland may have resulted in a limitation of her movement. Although Sylvia could provide evidence that the treatment was approved by the US Food and Drug Administration (FDA), there was no evidence of approval by the European Medicines Agency. The Ombudsman considered the submission from the insurer that the treatment was not in widespread use, and that even in the number of countries where it was being performed, its adoption was not universal. The Ombudsman took the view that the insurer arrived at its decision to decline Sylvia's claim for treatment abroad, in a reasonable and just manner. The Ombudsman partially upheld the complaint as the insurer misinformed Sylvia as to whether her pre-approval form could be completed by the Irish consultant or the overseas consultant. The insurance company was directed to make a compensatory payment in the sum of €500 to Sylvia.

Health Insurance Levy

Two quite different scenarios concerning the health insurance levy are highlighted in this Digest. The first highlights the problems that can arise if a customer does not cancel their first health insurance plan, when switching to another insurer.

In December 2019, Sam decided to move to a different insurance company (decision 2022-0000). However, he forgot to cancel his original health insurance policy for himself and his family, which stayed in place for the entire year. When Sam sought a refund of the premium from the first insurer, they refused, and Sam brought his complaint to the FSPO. Sam thought that he was entitled to a refund of the cost of the first policy, pointing out that he could not claim from both insurance policies for the same year. However, Sam's first insurer directed him to the general terms and conditions of his policy which specifically provided for a situation where customers have double insurance in place and outlined that the insurance company would only pay the portion of the claim that it was liable for in such a situation. The Ombudsman noted that Sam had been provided with copies of the rules brochure on various occasions and that cancellation of the insurance policy was required within 14 days of the renewal date. The Ombudsman accepted that the insurance company was entitled to refuse to refund the premium paid in respect of 2020 but noted that the company had refunded the premium paid for November 2020. The Ombudsman also noted that Sam had paid the government levy for himself and his family members on both policies for 2020, given that he had two policies in place.

Since Revenue guidelines state that only one Government levy is payable per person per year for private health insurance, the Ombudsman suggested that Sam should contact the Health Insurance Authority to explore whether the additional levy, in respect of each family member, could be refunded. However, as the first insurer had done nothing wrong, the Ombudsman did not uphold Sam's complaint.

The second decision summary published in this Digest concerns Emma (decision 2020-0483), who moved herself and her son onto her partner Brian's policy. Emma cancelled her existing policy and during the course of the cancellation, her insurer told her that it had paid the government health insurance levy for her and her son. However, when joining Brian's insurance policy, she was told by Brian's insurer that they had also paid the levy for them both. Emma requested that the levy be deducted from her premiums, but her new insurer advised her that it could not do so, as it had to charge every customer the same price for a particular plan. The Ombudsman noted that Emma's new insurer had not excluded Emma and her son from the statement it was required to provide to the Revenue Commissioners in relation to the levy. The insurer explained that it had failed to note the correct details on its system but that it would be rectified in the February 2020 return to Revenue. The Ombudsman noted that it was disappointing that the insurer did not take the necessary steps to ensure that a second levy was not paid in respect of Emma and her son, and that the obligation lay with the insurer to comply with each of its regulatory requirements. The Ombudsman was satisfied that the conduct of the insurer was both unreasonable and incorrect. The Ombudsman directed the insurer to pay Emma and Brian compensation of €2,750 and also brought the insurer's conduct to the attention of the Central Bank of Ireland.

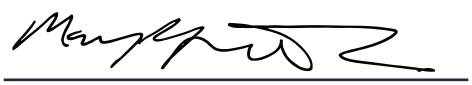
Acknowledgements

I would like to thank all our customers, whether complainants or providers, for their cooperation with our processes, as we seek to resolve the varied complaints we receive.

I wish to extend my thanks and acknowledge the support of the Chairperson, Maeve Dineen, and the members of the Financial Services and Pensions Ombudsman Council.

I also want to thank the FSPO Senior Management Team and all our staff for their ongoing commitment to delivering for our customers.

MaryRose McGovern



Financial Services and Pensions Ombudsman (Acting)
November 2022

Publication of FSPO decisions

The FSPO has the power to publish legally binding decisions in relation to complaints concerning financial service providers under Section 62 of the Financial Services and Pensions Ombudsman Act 2017.

The legislation requires that decisions should be published in a manner that ensures that a complainant is not identified by name, address or otherwise, and a provider is not identified by name or address. Publication must also comply with Data Protection legislation and regulations. Decisions appealed to the High Court are not published while they are the subject of legal proceedings.

When the Ombudsman issues a legally binding decision, that decision may be challenged by way of statutory appeal to the High Court within 35 calendar days from that date. For this reason, the FSPO does not publish decisions before the elapse of the 35-day period available to the parties to issue a statutory appeal to the High Court. In addition, decisions which have been appealed to the High Court are not published, pending the outcome of any such court proceedings.

Before any legally binding decision is published by the FSPO, it undertakes a rigorous and stringent review to ensure that the non-identification requirements of the Act are adhered to in order to protect the confidentiality of the parties.

The legislation also provides the FSPO with the power to publish case studies of decisions relating to pension providers, but not the full decision.

This Digest contains short summaries of a selection of 21 decisions. Some details within the summaries referenced in this Digest, such as names and locations, have been altered in order to protect the identity of the complainants. It is important to keep in mind that these are only short summaries.

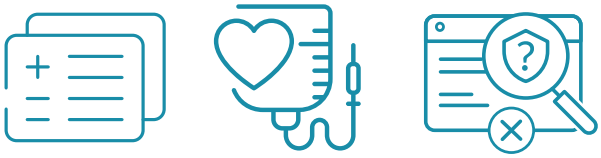
This Digest of Ombudsman's decisions is the eighth volume in a series of digests.

Each of the digests and all published decisions are available at www.fspo.ie.

Information on how to access decisions and search for areas or decisions of specific interest in the decisions database is included on page 14 of this Digest.

In addition to the periodic Digests that feature summaries and case studies of decisions issued, the Ombudsman publishes an **Overview of Complaints** for the previous year, by the end of quarter one each year, which includes:

- a summary of all complaints made to the FSPO
- a review of trends and patterns in the making of complaints to the FSPO
- a breakdown of the method by which all complaints made to the FSPO were dealt with
- a summary of the outcome of all complaints concluded or terminated during that calendar year



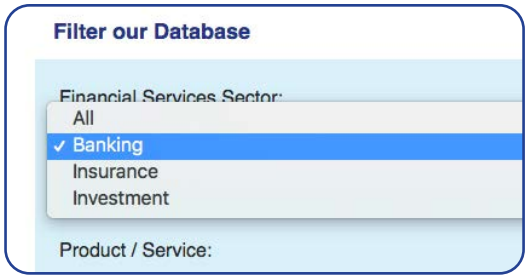
How to search our decisions on **www.fspo.ie**

Accessing our database of decisions

Our database of legally binding decisions is available online at www.fspo.ie/decisions.
To refine your search, you can apply one or a number of filters.

1 Applying **filters** to narrow your search

To filter our database of decisions, you can firstly select the relevant sector:



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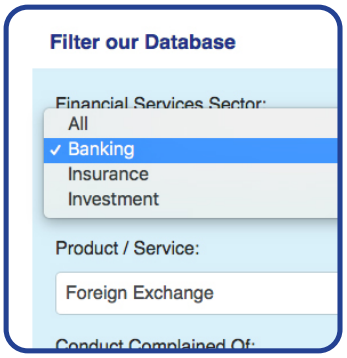
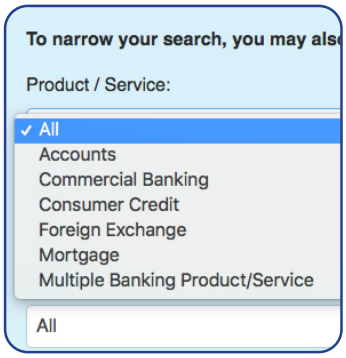
Having filtered by sector, the search tool will then help you to filter our **decisions** further by categories relevant to that sector such as:

- product / service
- conduct complained of

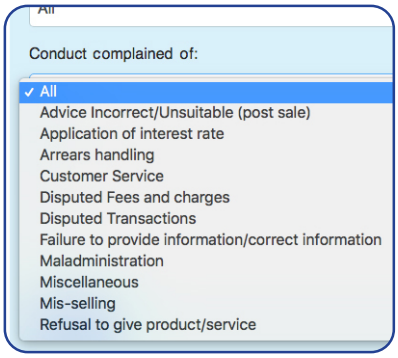
✓ Sector



✓ Product / Service



✓ Conduct complained of



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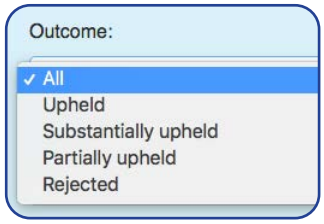
You can also filter our database of decisions by year, and by the outcome of the complaint, i.e. whether the Ombudsman Upheld, Substantially Upheld, Partially Upheld or Rejected the complaint.



Once you have found the decision you are looking for, click **View Document** to download the full text in PDF.

Decision 2019-0043 Read the full decision

Consumer refused cover for mammogram as no cover available after 70 years of age

Sally had a family history of breast cancer and held a health insurance policy since 1979. Sally complained to the FSPO as her insurer refused to cover the cost of mammograms on the basis that she was over 70 years of age.

Prior to renewing her policy in March 2016, she contacted her insurer to make enquiries about the health screening covered under her policy. Specifically, Sally queried whether mammograms and cancer checks were covered, and certain information was made available to her over the phone.

Sally's GP referred her for a mammogram in April 2016. Upon arriving at the hospital, she was informed that she would have to pay €200 for the procedure, as it was not covered under her health insurance policy. When Sally rang her insurer to query this, she was informed that her policy did not cover this procedure since she was over 70 years of age and so did not meet the criteria for mammograms. Sally pointed out that the insurer had paid for a mammogram in 2014, when she had already reached the age of 70. The insurance company confirmed that the previous payment had been made in error.

The insurer outlined that it follows the National Breast Check criteria to determine the eligibility of policyholders for mammogram screenings. These criteria recognise that breast cancer occurs infrequently in women under 40 and over 70. Based on this information, the insurance company provides cover to its customers who are aged between 40 and 69 years of age.

Referring to the policy information that was provided to Sally at the time of her policy renewal, the Ombudsman noted that the health screening section of the policy stated that customers should contact the insurer for details. The Ombudsman, having listened to recordings of the calls Sally made to the insurance company, was of the view that the responses received from her insurer were not satisfactory and may have caused Sally some confusion.

The Ombudsman noted that the insurer had paid, in error, for one mammogram after Sally turned 70, which was also likely to have led to confusion.

However, whilst the Ombudsman appreciated Sally's frustration that the mammogram criteria were based on general statistics which did not reflect her significant family history of breast cancer, nevertheless, the Ombudsman was satisfied that it remains a matter for the insurer to determine the extent of the cover it offers. Accordingly, the Ombudsman did not uphold the aspect of the complaint that the insurer had wrongfully or unreasonably refused to provide benefit for mammograms to Sally.

However, having examined all the evidence, the Ombudsman was not satisfied that the insurer had acted reasonably or transparently in its dealings with Sally. The Ombudsman was not satisfied that the information provided to Sally, including by way of telephone conversations prior to her renewal of her policy, was sufficiently clear. Accordingly, the Ombudsman directed the insurer to make a compensatory payment of €500 to Sally and directed the insurer to give consideration to setting out more transparently the particular age restrictions which impact the cover available to policy holders.

Decision 2018-0044 Read the full decision

Diagnostic investigations prior to policy upgrade determines condition was pre-existing

Matthew held a health insurance policy since 2012 and upgraded his policy cover on 1 January 2016.

In October 2015, Matthew had a routine blood test, the results of which showed a higher-than-normal PSA (prostate specific antigen) reading. Following a second high reading, as well as an MRI and biopsy, Matthew was diagnosed with early-stage prostate cancer in April 2016.

Matthew underwent a Robotic Assisted Laparoscopic Surgical Prostatectomy in May 2016, which cost €10,892. Having queried whether the cost would be covered by his insurance company, he was informed that he had signs and symptoms of the condition (raised PSA) in advance of upgrading his policy. Therefore, the terms of his old policy were applicable since there was a two-year waiting period applied to treatment for any ailment illness or condition that existed prior to the upgrade in cover. Accordingly, the insurance company stated that Matthew was only entitled to benefit of €6,441, being the maximum amount covered under his old policy.

Matthew argued that he was diagnosed with prostate cancer in April 2016 and it was the date of his diagnosis, not the instance of raised PSA in October 2015, which should dictate the level of cover. Accordingly, Matthew argued that the terms of his upgraded policy were applicable. While the insurer accepted that Mathew did not have a diagnosis of prostate cancer on 1 January 2016, it was the opinion of its medical advisors that there was biochemical evidence of prostate cancer, in the form of a raised PSA in October 2015 and that this was evidence that the condition pre-existed the upgrade of his policy and his prostate cancer diagnosis.

Matthew's policy terms and conditions defined a pre-existing condition as "*an ailment, illness, or condition where on the basis of the medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months*" prior to the start date of the policy.

The Ombudsman noted that in correspondence with the insurer, Matthew's GP stated that Matthew had no symptoms in October 2015 and that a raised PSA blood test is not a diagnosis.

Having considered the insurer's terms and conditions applicable to new registrations or renewals on or after 1 January 2016, together with the correspondence between the parties, the Ombudsman was satisfied that it was reasonable for the insurer to conclude that Matthew's condition pre-existed the upgrade in his cover on 1 January 2016, given that the diagnosis made on 15 April 2016 was arrived at as a result of investigations carried out as a result of Matthew's raised PSA reading in October 2015.

The Ombudsman was satisfied that the insurance company acted in accordance with the terms and conditions of Matthew's policy and did not uphold the complaint.

Decision 2018-0216 Read the full decision

Consumer proceeds with treatment following insurer's advice of no cover

Janet purchased a health insurance policy in 1993, which she renewed annually, including in 2016.

In July 2016, Janet had an eye test and was diagnosed with glaucoma. She was advised that there was a 50% chance that she would go blind and that this could happen at any time. Janet was given two treatment options, one of which provided a certain cure and one which would probably cure her diagnosis. Janet opted for the procedure which would definitely cure her diagnosis.

Janet enquired with her insurer, before having the procedure, whether the cost was covered by her policy. She was advised that it was not covered when it was being carried out for the treatment of glaucoma. Notwithstanding this, Janet decided to have the procedure and subsequently complained to the FPSO that her health insurer had wrongly or unfairly declined to reimburse her for the cost of the procedures.

The insurer explained that the particular procedure was specifically excluded from benefit under the terms and conditions of Janet's health insurance policy, when it was being carried out for the prevention of glaucoma, as it was not considered to be a proven form of treatment. The insurer stated that there are other proven treatments available, which would have been covered by the insurance policy. The insurer confirmed that it had advised Janet in advance of her having the procedure, that it would not be covered and that her consultant would also have been aware of this position, as the exclusion of the treatment is listed in the schedule of benefits for professional fees, which each consultant is provided with.

The Ombudsman noted that health insurance policies do not provide cover for every illness arising and that cover is always subject to the terms and conditions of the policy. The Ombudsman reviewed the exclusions and schedule of benefits applicable to Janet's policy and was satisfied that the terms and conditions of the policy clearly excluded cover for the procedure when it was being carried out for the treatment of glaucoma. The Ombudsman was also satisfied that the insurer had provided Janet with clear notice of the fact that the procedure would not be covered, prior to her having the procedure, and that Janet had chosen to proceed.

The Ombudsman did not uphold the complaint on the basis that the terms and conditions entitled the insurer to decline Janet's claim.

Decision 2019-0032 | Read the full decision

Consumer maintained that claim should not be considered outpatient treatment

Arthur held a health insurance policy since 2013. Arthur was diagnosed with an auto-immune skin condition, and he underwent a biopsy and excision to treat it in August 2016.

Following the procedure, Arthur made five separate claims to his insurance company for reimbursement of the medical expenses incurred, four of which were settled by his insurer. Arthur's fifth claim was declined on the grounds that Arthur had reached the benefit limit of €500 for out-patient treatment provided for under his policy.

Arthur complained because the insurance company, having accepted the first four claims, then decided that his fifth treatment should be assessed under the policy's outpatient benefit, although previous treatments had been accepted in error by the insurer as post-hospitalisation treatments.

Arthur's complaint was that outpatient benefits for more serious conditions, including his, should not be subject to a €500 limit and that it is a misuse of the outpatient limit to apply this to all outpatient events. Arthur sought to have the insurer's decision reversed and to have his ongoing treatment covered in full.

The insurer argued that Arthur's surgery was assessed correctly as a minor surgical outpatient procedure and was settled on that basis. Arthur's subsequent consultation and medication in August 2016 were assessed correctly as outpatient benefits. Arthur submitted two further invoices for consultations and medication in November 2016 and January 2017, which the insurance company subsequently recognised were incorrectly assessed initially, as post-hospitalisation benefit, when they should have been assessed under outpatient benefit. The insurer then assessed the fifth and final claim under the outpatient benefit and, at that stage, the outpatient benefit limit of €500 had been reached so the final claim was declined.

The Ombudsman noted that there was no documentary evidence to show that Arthur was treated on either a day-care or inpatient basis and that Arthur himself confirmed that his treatment was received as an outpatient.

Having considered the definitions contained in Arthur's insurance policy, the Ombudsman was satisfied that Arthur's procedures were correctly assessed as a minor surgical procedure on an outpatient basis, rather than day-care treatment. Accordingly, the Ombudsman was satisfied that Arthur's claims were ultimately correctly assessed as outpatient costs, although the insurance company had initially assessed two of those treatments as post-hospitalisation treatments.

The Ombudsman did not consider that the insurance company's conduct was wrongful and noted that a health insurance policy does not provide for every eventuality, and that the level of cover in place was chosen by Arthur and was subject to the terms and conditions set out in the policy documentation. The Ombudsman did not uphold the complaint.

Decision 2019-0043 | Read the full decision

Consumer maintained that declined claim was not related to a pre-existing condition

In April 2020, Sarah took out a new health insurance policy, having let her previous policy lapse.

Sarah suffered from Polycystic Ovary Syndrome (PCOS), which led to an irregular menstrual cycle. The terms and conditions of Sarah's new policy specifically provided that any pre-existing conditions, defined as those which existed within the 6-month period immediately preceding the inception of a policy, were subject to a five-year waiting period before being eligible for cover. Sarah was aware of these terms and knew that her PCOS fell within the pre-existing condition.

In August 2020, Sarah visited her GP with fertility related concerns and was referred for an ultrasound due to her irregular menstrual cycle.

In April 2021, Sarah had a pelvic ultrasound, which revealed an abnormality in the right ovary. Consequently, Sarah was referred to a consultant gynecologist and obstetrician. Sarah was subsequently diagnosed with a dermoid cyst, requiring surgery. She was advised that it was a new diagnosis, entirely independent from PCOS.

In July 2021, Sarah advised her health insurer by phone that she was due to undergo surgery and queried whether her policy covered the surgery. During the call, when Sarah was asked how long she had had symptoms for, she responded that she did not have any symptoms but that she had a scan in April and was referred to a consultant straightaway because it was believed she had a benign tumour. The insurer enquired as to what symptoms Sarah experienced that had led to the scan. Sarah responded that it was an ovarian check-up. The insurer advised Sarah that the relevant medical notes would determine the date of onset of symptoms and if it was after she took out the policy, she would be covered. The insurance company also advised that if the symptom onset date was deemed to be prior to her taking out cover, she would not be covered.

In July 2021, Sarah underwent surgery. Following the surgery, her insurer declined to cover the costs of the surgery on the basis that Sarah's symptoms (being her irregular menstrual cycle) which prompted the ultrasound, existed in the six months prior to Sarah taking out the policy, and was therefore subject to the five-year waiting period set out in the policy rules, before cover would be available under the policy.

The Ombudsman was satisfied that the insurer was entitled to form the reasonable opinion that the surgery was for a pre-existing condition, and therefore was entitled to decline the claim. The Ombudsman did not uphold the complaint.

Decision 2019-0170 Read the full decision

Claim paid for hospital not covered by policy, causing confusion

Emily and her daughter Gemma held a health insurance policy since 2015.

In February 2015, Emily fell and injured her ribs. Gemma twice rang their insurance company to enquire what medical facilities were covered by their policy and she was informed that her mother was covered to attend three different facilities. However, Emily chose to attend a private facility not covered by her policy.

Although the private facility was not covered by her policy, the insurance company paid for the cost of Emily's treatment in the private facility, having done so in error. This led Emily and Gemma to believe that they were covered for treatment in the private clinic.

Emily attended the private clinic again in March 2018 for a CT scan. When she submitted her claim of €600 to her insurance company, she was informed that she was not covered for treatment and that she would have to bear the costs herself. Emily and Gemma claimed that as the insurance company had covered the previous claim, they had been led to believe that treatment in the private clinic was covered under their policy. Accordingly, they were of the view that the insurance company should reimburse them for the €600 paid.

The insurance company explained that on numerous occasions, Emily and Gemma were sent documentation setting out the treatment facilities covered by their policy. This documentation confirmed that the private clinic in question was specifically excluded from the policy.

On the basis that the insurance company had not informed Emily and Gemma that the first claim had been paid in error and in recognition of the confusion this may have caused, the insurance company made an offer of €295 to cover the CT scan performed in March 2018. In addition, the insurance company agreed to make an ex-gratia payment of €50.

The Ombudsman noted that Emily and Gemma's policy specifically excluded treatment in the private clinic at issue. The Ombudsman also noted that the insurance company had not informed Emily and Gemma during any of the phone calls between them that they could attend the private clinic.

However, the Ombudsman accepted that Emily and Gemma may have been confused by the insurance company paying their first claim in 2015. The Ombudsman was of the opinion that the insurance company should have notified Emily and Gemma of the mistake, as soon as it came to light.

The Ombudsman did not uphold the complaint on the basis that the offer by the insurance company to make a payment of €295 to Emily and Gemma in respect of the CT scan, as well as an ex-gratia payment of €50 because of the confusion caused, was reasonable in the circumstances.

Decision 2019-0416 Read the full decision

Customer not advised of change in benefits when checking cover

Alice had a health insurance policy which included dental cover. Alice required substantial dental work, including crowns and bridges. In advance of the procedures, Alice phoned her insurer to query the extent of her cover. During the call, Alice was advised that her insurance would cover 70% of the cost of one bridge and 70% of the costs of crowns up to a maximum of €600. However, five days after this call, Alice's policy was renewed and some of the terms of her policy changed, including a limitation on the amount that could be claimed for bridges. Alice had not been advised of these pending changes during her call with the insurer.

Alice underwent the dental work, which ultimately cost €7,000. Given what Alice had been advised by her insurer, she expected to be reimbursed the sum of €3,000. However, when she submitted her claim her insurer paid out €1,200 on the basis of the amendments that had been made to her policy when it was renewed.

Alice argued that the changes to her policy were not explained properly to her and that had she known that the relevant terms of the policy were due to change, she would have managed her treatment differently. Alice complained to the FPSO that her insurance company acted improperly by not providing accurate information on her future coverage and secondly, that it failed in how it processed and handled both the claim and her complaint.

The insurer maintained that the advice provided during the phone call was correct and in accordance with policy schedule at the time of the call and that therefore it was not misleading. The insurer also noted that Alice had indicated that she was going to have the dental work done regardless, and therefore its advice could not have had a bearing on her decision. The insurer accepted that it paid the settlement monies to an incorrect account, which was subsequently rectified. In respect of the complaint handling, the insurer stated that it had complied with the Consumer Protection Code (CPC).

The Ombudsman noted that the insurer accepted that it was at fault for the payment not being processed properly. In relation to the handling of the complaint the Ombudsman found that the insurance company had acted within the timeframe provided for by the CPC.

However, the Ombudsman found that it was unfair and misleading that Alice was not informed during her phone call with the insurance company querying her level of cover, that the relevant section of the table of benefits was due to change imminently. The Ombudsman referred to the fact that the CPC requires a regulated entity to ensure that all information provided to a consumer is clear, accurate, up to date and that all key information be brought to the attention of the consumer. The Ombudsman determined that this standard had not been met.

The Ombudsman was satisfied that the insurer should have advised Alice that the coverage was due to materially change within five days, to give her the most accurate information and to allow Alice to decide on the best course of treatment.

The Ombudsman substantially upheld the complaint and directed the insurer to pay €3,000 in compensation to Alice for the loss, expense, and inconvenience caused.

Decision 2020-0132 Read the full decision

Claim declined as treatment not covered in the policy benefits

Sophie held a health insurance policy. She was suffering from ongoing swelling and pain in her left leg and her GP advised liposuction, as a therapeutic procedure to control her symptoms. Her consultant plastic surgeon's opinion was that the procedure was not cosmetic.

She contacted her health insurance company to enquire as to whether the cost of therapeutic liposuction treatment to her leg under general anesthetic, would be covered. Her insurer advised that liposuction was not covered by her policy. Sophie was unable to pay for the surgery herself and brought a complaint to the FSPO stating that her claim was wrongfully or unfairly declined and sought to have the cost of treatment covered by her health insurer.

The insurer maintained that it declined to cover the procedure for several reasons. Firstly, on the basis that liposuction was not listed as a treatment or procedure in the policy schedule of benefits. The insurer explained that the schedule is updated annually with new or innovative procedures which may be medically necessary or may have become the standard of care. The insurer had advised Sophie's consultant plastic surgeon of the opportunity to submit information to have a new procedure considered for addition to its schedule of benefits, however, no submission was ever received.

Secondly, the insurer said that it could not establish the medical necessity for the treatment. It was concerned that the liposuction request was in contravention of its scheme rules which specifically excluded benefits for cosmetic treatment. Although Sophie's consultant plastic surgeon held the opinion that it was not a cosmetic procedure, the insurer noted that this differed from previous correspondence from her consultant vascular surgeon where he described the swelling as "uncomfortable and aesthetically displeasing".

Thirdly, the insurer noted that the proposed liposuction treatment was to be carried out at a private hospital, which was not covered by Sophie's policy.

The Ombudsman was satisfied that the terms and conditions of Sophie's health insurance policy excluded cover for cosmetic treatment such as liposuction, except where it is for the correction of accidental disfigurement, significant congenital disfigurement or significant disfigurement due to disease, the need for which would have to be supported by medical evidence. The Ombudsman also noted that liposuction was not a treatment or procedure which was listed in the policy's schedule of benefits. The Ombudsman referred to the correspondence from Sophie's various medical practitioners and was satisfied that it was reasonable for the insurer to conclude that the evidence before it did not establish a medical necessity for the treatment.

Sophie's complaint was not upheld.

Decision 2020-0189 Read the full decision ▶

Claim declined for removal of tumour deemed to be pre-existing

Clara purchased a health insurance policy on 5 January 2019 and was issued a welcome pack email that contained a link to the policy rules booklet. These rules advised that waiting periods were applicable to any pre-existing conditions that existed at any time in the period of 6 months immediately preceding the purchase of the policy.

On 6 January 2019, Clara attended her GP for a repeat prescription and explained that she had been experiencing back pain for a couple of months. She was referred for a scan, which showed a tumour in her back. On 30 March 2019, Clara underwent surgery.

Clara's insurer declined to cover the cost of her surgery on the basis that it was a pre-existing condition. Clara complained to the FPSO that the insurer wrongfully or unfairly declined her health insurance claim and had misinterpreted the definition of 'pre-existing condition'. She maintained that since she was unaware of her condition at the time of incepting the policy, her claim should be covered.

The insurer concluded that based on the information provided to its medical practice team, Clara's back pain which prompted the investigation that led to the diagnosis and subsequent surgery, existed before Clara took out her policy. In particular, the insurer noted that Clara confirmed to her surgeon that she experienced back pain in October 2018 and December 2018.

The insurer referred to the definition of "pre-existing condition" as contained in the policy documentation, which defined a pre-existing condition as "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 six months immediately preceding the day you took out a Health Insurance Contract for the first time". The insurer maintained that the signs and symptoms which led to Clara's diagnosis existed before Clara took out the policy on 5 January 2019.

The Ombudsman accepted that Clara had symptoms in October 2018 and December 2018. Having considered the terms and conditions of the policy, the Ombudsman concluded that the insurer was correct in its interpretation of the definition of "pre-existing condition" and accepted that the insurance company was entitled to refuse to pay the claim, based on the medical evidence that the symptoms occurred within the 6 months prior to the inception of the policy.

The Ombudsman accepted that Clara did not know what was causing her symptoms until after the inception of the policy. However, this did not alter the fact that the symptoms were present before the inception of the policy. Clara's complaint was not upheld.

Decision 2020-0276 Read the full decision

Claim declined as customer advised prior to procedure that the hospital wasn't covered

Ciarán was diagnosed with a spinal condition requiring surgery in November 2018. His surgery was performed in a private hospital in Dublin, at a cost of almost €23,000. Ciarán was informed by his insurer on multiple occasions prior to the surgery, that his policy did not provide cover for the surgery to be performed in the private hospital in Dublin, but that it would cover surgery in a private hospital in Cork, that was part of the same hospital group.

Ciarán asked his insurer to subsidise the cost of the procedure in the Dublin hospital, up to the value it would have paid if the procedure was carried out in the Cork hospital. Ciarán complained to the FSPO that his insurer wrongly or unfairly declined to cover, or contribute to, the cost of the surgery in Dublin, which would have been covered in full had it been performed by the same surgeon, but in a different hospital.

Ciarán explained that as the Cork hospital did not have an Intensive Care Unit (ICU), his consultant surgeon was unwilling to complete the surgery in Cork. Ciarán submitted that he did not choose to have the procedure in Dublin, but that he deferred to the judgment of his consultant who stated that he required the additional facilities available in the Dublin hospital.

The insurer provided Ciarán with the table of benefits relevant to his policy upon his renewal on 1 July 2018, which clearly showed that his policy offered no cover in the Dublin hospital where his surgery was subsequently performed, except for specialist cardiac procedures and certain specified orthopaedic procedures. In addition, representatives of the insurer clearly explained on several occasions by telephone, in advance of his surgery, that his policy did not provide him with cover for the procedure in the Dublin hospital. Ciarán was also advised on several occasions that if he had the surgery in the Dublin hospital, no portion of the bill would be covered by the insurer.

The insurer also noted that the Dublin hospital was not the only option available. It advised Ciarán that the procedure also appeared on other private hospital contracts that Ciarán had access to, with two such hospitals in Galway and one in Dublin. Nevertheless, Ciarán ultimately chose to have the procedure carried out in the Dublin hospital, in the knowledge that his chosen level of health insurance cover, would not provide him with cover.

The Ombudsman noted that Ciarán had initially requested his insurer to subsidise the cost of the procedure in the Dublin hospital, up to the value it would pay if the procedure was carried out in the Cork hospital. However, subsequently, due to the level of stress he felt he had incurred in dealing with his insurer, Ciarán sought full cover for the procedure. The Ombudsman did not consider it reasonable for Ciarán to expect the insurer to make payment based on any other arrangement, other than the parties' agreed contractual terms.

The Ombudsman was satisfied that Ciarán opted to have the procedure in a hospital where he was aware he had no cover. The Ombudsman noted that health insurance contracts cannot provide for every eventuality and that Ciarán had chosen the level of cover provided by his policy and it would not be reasonable to expect the insurer to make payment for a procedure not covered by his policy. The Ombudsman held that the insurer acted reasonably in declining Ciarán's claim and did not uphold the complaint.

Decision 2020-0437 Read the full decision

Claim declined as cover for private hospitals not available for pre-existing conditions for 2 years

Fergal held a health insurance policy which he upgraded in February 2019. This upgrade included cover for private hospitals. However, a two-year waiting period applied for treatment in private hospitals for any disease, illness or injury which existed prior to the upgrade in cover. Fergal underwent treatment in a hospital in 2019 and subsequently made a claim for the medical expenses incurred totalling over €4,000. The claim was refused on the grounds that the medical condition he received treatment for pre-existed the policy upgrade and the private hospital was therefore not covered due to the two-year waiting period.

The insurer stated that the information furnished with the claim indicated that the symptoms which prompted Fergal's admission to hospital were present prior to him upgrading his cover. The information was also reviewed by an external medical advisor, who agreed that the onset of symptoms was prior to Fergal upgrading his cover.

The Ombudsman noted that on 25 February 2019, Fergal's GP referred him to a consultant for review in respect of a persistent headache, amongst other symptoms, and noted in the letter of referral that Fergal had been unwell since mid-December 2018. The Ombudsman was satisfied that the insurer was entitled to form the opinion that it was these same symptoms that gave rise to Fergal's admission to hospital for treatment and that as the symptoms were present from December 2018, the insurer was entitled to assess Fergal's claim against the level of cover he held prior to 26 February 2019, because it was a condition that pre-existed the policy upgrade.

Having listened to the audio files between Fergal and the insurer, the Ombudsman was satisfied that during February and March 2019, the insurer's agents were professional and fair to Fergal. They clearly explained that there was an additional waiting period of two years for him to be covered for admission to private hospitals. The evidence from the audio files and the webchat screenshots submitted to the Ombudsman confirmed that the insurer's agents repeated details of the pre-existing conditions waiting period, to ensure that Fergal understood the position fully.

The Ombudsman also noted that the two-year waiting period was disclosed in the rules booklet when Fergal first purchased the health insurance policy, and when the policy documentation was sent to him at the time of his policy upgrade.

The Ombudsman was satisfied that the insurer had met its obligations to Fergal and was satisfied that the refusal to admit the claim was a reasonable one. The Ombudsman was satisfied that the insurer acted in accordance with the terms and conditions of the policy in determining that cover in the private hospital was not available to Fergal, since the condition giving rise to his hospital admission, existed before he upgraded his cover in February 2019. Fergal's complaint was not upheld.

Decision 2020-0483 Read the full decision

Health insurance levy paid upon policy cancellation and inception of new policy

Emma held a health insurance policy which also covered her son and renewed her policy in January 2018. Emma and her partner Brian later decided that it would be best for Emma and her son to join Brian's health insurance policy, which was held with a different insurance company. Brian's policy was renewed annually in March. Emma therefore cancelled her existing policy in March 2018. In the course of complying with her instructions, Emma's insurance company told her that the annual Government levy had already been paid by it for both Emma and her son. However, when Emma and her son were added to Brian's policy, Brian's insurer also paid the Government levy in respect of Emma and her son. Emma and Brian argued that Revenue guidelines advise that there is only one Government levy per person per year payable for private health insurance, and that as Emma's original insurance company had already paid this levy for Emma and her son, the new health insurance company should deduct the sum of the Government levy already paid from their premium payments. The total sum in dispute amounted to €430.71.

Brian's insurance company stated that it was not in a position to waive the Government levy on the policy. The Ombudsman accepted the insurance company's position that Section 7 of the Health Insurance Act 1994 prohibits an insurance company from charging different people different prices for the same policy in the same accounting period. The Ombudsman also accepted that the insurance company must comply with Revenue guidelines in relation to the levy. Brian's insurer argued that Revenue guidelines specify that only one levy is payable per year per person, to avoid the payment of duplicate levies, should a person move from one insurer to another within the same year, as occurred with Emma and her son. However, Brian's insurer stated that despite this, the guidelines do not allow for refunds to be issued where the levy has been paid by the first insurer, as it would result in some people paying a different price for the same policy over the same period.

Brian's insurer did not dispute that Emma's previous insurance company had already paid a levy to the Revenue Commissioners for the period 1 January 2018 to 31 December 2018 and the Ombudsman stated that it was clear from the Revenue guidelines that the Revenue Commissioners would not be seeking this levy again in respect of Emma and her son for the same period.

The Ombudsman queried whether Brian's insurer had made any attempt to exclude Emma and her son from the statement required to be delivered by it to the Revenue Commissioners for the same period, and if not, why not. Brian's insurer responded that Emma and her son were not excluded from the levy return in May 2018, as the insurer had failed to note the correct details on its system but that it would be rectified in the insurer's February 2020 return. The Ombudsman was of the view that it was unacceptable that the insurer only acknowledged this failure when the question was put directly to it by the Ombudsman. The Ombudsman did not accept that the insurer followed the Revenue guidelines to ensure that only one levy was paid for each insured in any 12-month period.

The insurer acknowledged shortfalls in its customer service in dealing with Emma and Brian's complaint and offered the sum of €750 to resolve the complaint. Emma and Brian did not accept this goodwill payment. However, given the insurer's acknowledgment and its goodwill offer, the Ombudsman did not make any further comment on the manner in which the insurer dealt with the complaint.

The Ombudsman noted that it was disappointing that the insurer did not take the necessary steps to ensure that a second levy was not paid in respect of Emma and her son. Notwithstanding the insurer's requirement to charge all of its policyholders the same premium price, the Ombudsman took the view that the obligation lay with the insurer to comply with each of its regulatory requirements. The Ombudsman was satisfied that the conduct of the insurer was both unreasonable and incorrect. On that basis, the Ombudsman directed the insurer to pay Emma and Brian compensation of €2,750. The Ombudsman also brought the insurer's conduct to the attention of the Central Bank of Ireland.

Decision 2022-0000 | Read the full decision

Customer requests premium refund as two health insurance policies held for the same year

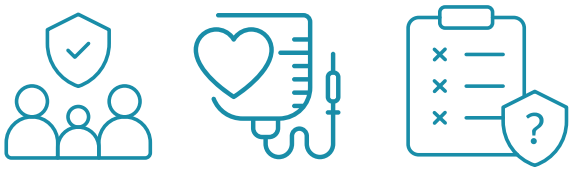
Sam held a health insurance policy in respect of himself and his family, which renewed in December every year. In December 2019, Sam decided to move to a different insurance company. However, he forgot to cancel the original health insurance policy, which stayed in place for the entire year. Sam thought that his wife had cancelled it and he only became aware that they had never cancelled the original policy when he received a renewal call from his original insurers in December 2020. Sam sought a refund from the original insurance company for the full 12-month period of 2020. This was refused by the insurance company, however, it agreed to refund the instalment for November 2020. Sam complained to the FPSO, seeking a refund of the entire premium for 2020.

Sam was of the view that because any claims for medical expenses would have been made to his new health insurer, any claim that he subsequently made to the original insurance company would have been rightly turned down and therefore, the cover he had paid for was not being provided by the original insurance company. The insurance company disagreed and confirmed that the policy was active for the year 2020 and that Sam could have made a claim on the policy. The insurance company pointed to the fact that the general terms and conditions of Sam's policy specifically provides for a situation where customers have double insurance in place and outlines that the insurance company would only pay the portion of the claim that it was liable for in such a situation.

The insurance company outlined to the Ombudsman that Sam had been provided with many copies of the company's rules brochures over the years, including in October 2019 prior to his last renewal. The rules brochure clearly set out that the contract is for a period of one year and that there would be no refund of premium if the policy was cancelled mid-year. It further set out the procedure for cancelling the policy. The insurance company explained that in accordance with the rules, Sam's policy renewed automatically each year and that Sam had not cancelled the policy in 2019.

The Ombudsman noted that Sam had been provided with copies of the rules brochure on various occasions. In particular, the Ombudsman noted the rule that required notice of cancellation of the insurance contract must be given within 14 days of receipt of the Membership Certificate by the customer. If the customer does not provide written notice of cancellation within the 14-day period, they are bound to a one-year policy and refunds will not be given to customers who cancel after the 14-day period. The Ombudsman was satisfied that this wording was plain and clear and that the insurance company had complied with its obligations under the Consumer Protection Code. The Ombudsman was also satisfied that the insurance company does not stop or exclude cover in situations where a customer has double insurance in place. For that reason, Sam had a contractual entitlement to make a claim to his original insurance company for medical treatment during 2020, even though he had another insurance policy in place. The Ombudsman accepted that the insurance company was entitled to refuse to refund the premium paid in respect of 2020 but noted that the company had refunded the premium paid for November 2020.

The Ombudsman noted that every insurance premium paid to a health insurance provider includes a Government health insurance levy that is paid directly to the Revenue. However, pursuant to Revenue guidelines, only one Government levy is payable per person per year for private health insurance. Sam, however, paid a double levy for the year 2020 in respect of each of his family members (through no fault of the insurance companies), given that he had two policies in place. The Ombudsman suggested that Sam should contact the Health Insurance Authority to explore whether the additional levy, in respect of each family member, could be refunded. The Ombudsman did not uphold Sam's complaint.



Decision 2021-0027 Read the full decision

Complaint for treatment abroad declined

Debbie applied to her insurer in January 2015 to be covered for treatment in another EU country. Debbie had an aggressive illness which she described as leaving her totally disabled and confirmed that after her treatment, her symptoms receded. The total cost of the treatment came to €67,778.03.

In refusing the application to be covered for treatment abroad, the insurer referred to its rules for treatment outside Ireland, which stated that it will not provide cover to a member who travels abroad to get treatment without prior approval and without specified criteria being satisfied as follows:

1. There is reliable evidence that the procedure has been the subject of well - controlled studies, which have determined its safety and efficacy compared with standard treatments;
2. There is reliable evidence amongst experts regarding the procedure that further studies or clinical trials are not necessary to determine its safety or effectiveness as compared with standard treatments; and
3. Long-term outcomes are available, defined as a five-year follow up.

When communicating its refusal of Debbie's claim, the insurer stated that Debbie's case was discussed by its medical advice group in March 2015 and that the group agreed that the treatment was not consistent with a proven form of treatment for her condition, in accordance with the above listed criteria. The insurer submitted the minutes from the meeting of the medical advice group to the Ombudsman, who noted that the minutes clearly stated that more information was needed to determine whether or not the case met the criteria. There was no evidence put before the Ombudsman that any further information was provided before the insurer came to its decision.

In the Ombudsman's view, it was remarkable that despite the minutes of the medical advice group making no reference to the "experimental" nature of the treatment, the insurer's decision stated that the treatment requested by Debbie was "experimental" and it used the absence of any long-term study as a reason for denying the claim. Following Debbie's complaint to the Ombudsman, the insurer furnished a far more detailed explanation of its decision to refuse her claim.

The Ombudsman decided that the insurance company's decision to reject the claim was unreasonable and unjust on the basis that firstly, the claim was rejected despite the medical group's request for more information. Secondly, the insurance company did not review Debbie's claim between March and May 2015 and thirdly, the insurance company only came to a reasoned decision as to Debbie's claim on 3 June 2016 when the matter was before the Ombudsman. The Ombudsman was also particularly concerned by the insurer's "manifestly incorrect" assertion that the medical advice group considered all available literature and agreed that the treatment was not consistent with a proven form of treatment, when there was no evidence that the medical advice group had considered any literature.

The Ombudsman further noted that the three-and-a-half-month delay in communicating its decision to Debbie was extremely poor, given her precarious health and the urgency she faced in receiving appropriate medical treatment. The Ombudsman therefore accepted that the insurer had arrived at its decision in an unacceptable and unjust manner and therefore its conduct in refusing Debbie's claim was unreasonable.

The Ombudsman upheld Debbie's complaint and directed the insurer to admit her claim and reimburse her for the medical ancillary expenses incurred subject to any excess/financial limitations on her policy. The insurer was also directed to pay the sum of €2,000 in compensation to Debbie for the inconvenience caused.

Decision 2021-0158 Read the full decision

Historic outpatient claim of ex-policy holder declined

Sonia held a private health insurance policy from 2009. In December 2014, Sonia changed her level of cover, which she then held until 2016, when she cancelled her policy. In December 2018, two years after cancelling her policy, Sonia submitted a claim for expenses incurred in 2014. The insurer declined the claim as it was outside the time limits for claims, under the terms of the insurance policy. Sonia complained to the FSPO that the insurer had wrongfully refused her claim.

The insurer outlined that there was a time limit of 12 months to make a claim for out-patient medical expenses. The insurer confirmed that this time limit had always been in place but had not always been strictly applied by the insurer. However, from August 2017 onwards, the insurer decided to strictly enforce this 12-month rule. The insurer confirmed that all customers were advised of this change but pointed out that because Sonia had already cancelled her policy, they had not written to her. However, acknowledging that it did not always adhere to the 12-month rule when Sonia had held a policy, the insurance company agreed to assess her expenses on an ex-gratia basis under the level of cover she held from 2009 to December 2014. It advised that the outpatient excess of €440 in respect of these claims would still apply.

The Ombudsman noted that the terms and conditions of the 2009 and 2014 rules brochure clearly stated that outpatient claims would only be paid on receipt of a written claim within 12 months from the date of the nonsurgical outpatient treatment, and 6 months from the date of any other treatment. The terms also expressly stated that the insurer may change the procedure for making a claim and if it did, it would write to policyholders to let them know.

The Ombudsman accepted that it would not be practical to expect the insurer to write to every former policyholder, to inform them of policy changes and was satisfied that under the terms of the rules brochure that applied to Sonia's policy, the insurance company was entitled to apply the 12-month rule. The Ombudsman was satisfied that the insurance company was entitled to decline Sonia's claim given the length of time between the treatment and the claim being submitted.

However, the Ombudsman noted the insurance company's ex-gratia offer to process the claim in line with the previous level of cover held by Sonia at the time when the outpatient expenses were incurred and was satisfied that it was a reasonable and appropriate approach in the circumstances. The Ombudsman did not uphold the complaint.

Decision 2021-0379 Read the full decision

Customer proceeds with procedure despite insurer's confirmation of no cover

Alanna and John held a health insurance policy since January 2017. In June 2019, Alanna was suffering with back pain. Following an MRI scan, she was referred for plasma treatment to relieve the pain and her consultant recommended that she have treatment every 4-6 weeks, with three procedures in total. Alanna's insurer paid for the first round of treatment but refused to cover the second one as Alanna and John's policy only provided for one such procedure to be covered within a six-month period. Alanna's treatment had been planned around the delivery of three procedures within a six-month period and Alanna and John complained to the FSPO, seeking to have the three procedures paid for by the insurance company.

Alanna's insurer confirmed that it paid the claim in respect of Alanna's first procedure in September 2019. However, in October 2019, Alanna's consultant notified Alanna and John that the insurance company would not provide cover for the second procedure, which was due to be performed in two days' time. Alanna and John checked the insurer's online portal and received an email confirming cover for the procedure. John then contacted the insurance company by telephone to confirm the position. The insurer informed them that Alanna was eligible for cover for one such procedure every six months. During the call John was advised that pre-authorisation could be sought from Alanna's consultant to have additional cover granted by submitting medical reasons behind the recommendation for the repeat procedure to be carried out.

The Ombudsman noted that the insurer clearly advised John that the only way the second procedure would be covered, was through Alanna's consultant seeking pre-authorisation. This process was explained to John who indicated that he would ask the consultant to do so. However, no such pre-authorisation was sought from the consultant, and the treatment went ahead.

Having considered the documentary evidence and listened to the recording of the telephone calls between the insurance company and John, the Ombudsman was satisfied that Alanna was notified in advance of undergoing the second procedure that the insurer would not cover the associated cost. The Ombudsman also noted that Alanna's consultant was on notice of, and ought to have been aware of, the criteria relevant to the procedure in question.

The Ombudsman acknowledged that the email received by John and Alanna from the insurer's online portal, confirming cover, was confusing. However, the Ombudsman did not think that this was sufficient to warrant upholding the complaint as John had subsequently telephoned the insurer and it was clearly explained to him that the second and third procedures would not be covered if they were undertaken within a six-month period of the first procedure.

The Ombudsman was satisfied that the insurer's conduct in refusing to cover the claim was reasonable and held that there was no reasonable basis upon which the complaint could be upheld.



Decision 2021-0380 Read the full decision

Policy holders submit outpatient claim outside of the policy's time limits

Stuart and Ruth purchased a health insurance policy in January 2014 and subsequently renewed it every year up to and including 2018. In early 2020, a year after changing to another insurance company, Stuart and Ruth submitted receipts for outpatient medical expenses covering the period from 2014 to 2018 to their original insurer. The insurer declined to pay the claim, stating that claims for medical expenses must be made within 12 months of the date of the receipt. Stuart and Ruth argued that they were never informed of this time limit and made a complaint to the FSPO seeking reimbursement for all the receipts submitted.

The insurance company confirmed that the 12-month time limit relating to medical expenses was in existence from the time that Stuart and Ruth first took out a policy. However, it was not strictly enforced until 2018. The time limit was set out in the rules booklet sent to Stuart and Ruth when they took out their policy and was also brought to their attention in November 2017, when strict enforcement of the time limit was being introduced. The insurer had notified policyholders that there would be a grace period of 12 months to submit any previous years' everyday medical expenses, before the full implementation of the strict time limit. Stuart and Ruth did not submit claims until almost three years later.

Stuart and Ruth were informed on a call with the insurer in January 2017 that they could submit everyday medical expenses receipts, and that the insurance company would refund between 50% and 70% of the costs. However, the insurer's representative incorrectly stated that there was no time limit applicable to these claims.

The Ombudsman was satisfied that the insurance company took appropriate steps to inform Stuart and Ruth that they were entitled to submit claims in respect of their everyday medical expenses. This benefit was included as part of the initial policy documentation furnished to them when they purchased the insurance policy. The Ombudsman noted that when it was decided that the 12-month rule was going to be 'strictly enforced' from 2018 onwards, the insurance company took steps to inform its policyholders of this development and provided a grace period within which to submit any outstanding receipts that fell outside the 12-month permissible timeframe.

The Ombudsman felt that the telephone conversation that took place in January 2017, in which the insurance company's agent incorrectly stated that there was no time limit on making claims for expenses, was noteworthy. However, the Ombudsman was satisfied that this conversation did not alter the position as Stuart and Ruth did not send in a claim after this call. They were then specifically notified, 10 months later, of the pending strict implementation of the 12-month time limit.

The Ombudsman was satisfied that the insurer's conduct, in refusing to admit the claims, was reasonable and that it had acted in accordance with the terms and conditions of the policy in declining Stuart and Ruth's claims. The complaint was not upheld.



Decision 2021-0433 Read the full decision

Claim declined for treatment abroad as it was not an approved form of treatment

In September 2018, Sylvia's daughter, Ella, underwent surgery for scoliosis in another European country, as the only form of treatment available in Ireland may have resulted in a limitation of movement. In order to claim for the treatment abroad, Ella's referring consultant was required to complete a prior approval form. However, her consultant in Ireland would not complete this, as he was not familiar with the surgery proposed.

Following her daughter's surgery, Sylvia sought to claim back the cost of the surgery under her health insurance policy. There were various phone calls between Sylvia and her insurer in relation to the requirement for a consultant in Ireland to complete a prior approval form. However, in June 2019, the insurer advised Sylvia that if she could get the consultant in the treating country to fill out the form, the insurer may accept it. This was submitted, but the insurer then declined the claim on the basis that (i) the Approval for Treatment Abroad Form was not completed by a referring consultant in Ireland and (ii) the procedure itself was not an approved form of treatment. Sylvia complained to the FSPO, seeking reimbursement of the surgical expenses.

Sylvia submitted medical evidence showing that the procedure was approved by the US Food and Drug Administration (FDA). Additionally, Sylvia said that the procedure was approved and in addition, it was not considered experimental in the European country where Ella's treatment was carried out.

The insurer explained that the terms and conditions of the policy relating to treatment abroad required the treatment being undertaken to be considered by the insurer's Medical Director to be "generally accepted as a proven form of treatment". To satisfy this, the insurer required that the procedure had been the subject of well-controlled studies, that further studies or clinical trials were not necessary to determine its safety, and long-term outcomes were available. The insurer referenced five sources in support of its conclusion that experts in the area agreed that this particular treatment needed further studies to determine its safety and effectiveness.

The Ombudsman accepted that Sylvia supplied information that the procedure was FDA approved but noted that there was no evidence of approval by the European Medicines Agency.

The Ombudsman considered the submission from the insurer that the treatment was not in widespread use, and that even in the number of countries where it was being performed, its adoption was not universal. The Ombudsman accepted that the procedure was a new form of treatment and subject of ongoing trials. Accordingly, the Ombudsman held that the insurer arrived at its decision to decline Sylvia's claim for treatment abroad, in a reasonable and just manner.

The Ombudsman noted that the insurer had made a goodwill gesture offer of €250 in recognition of its error in citing the prior approval form not being completed by an Irish consultant as a reason for refusing benefit, after it had previously agreed to accept the form from the consultant in the country where treatment was carried out. The Ombudsman partially upheld the complaint and directed the insurance company to make a compensatory payment in the sum of €500 to Sylvia.

Decision 2022-0130 | Read the full decision

Claim for midwife homebirth expenses declined following delivery of baby in hospital

Seán purchased health insurance in 2019, which covered homebirth services. Seán's wife intended to have a homebirth, using a midwife. However, due to medical complications she could not go ahead with the homebirth and was admitted to hospital as a public patient to deliver the baby. Prior to the delivery, a midwife had visited their home, to prepare for the homebirth. The total cost of the preparation amounted to €700. Following the baby's birth, Seán made a claim for the midwife's expenses through his insurance company's app. The claim was rejected as his policy only covered the birth of a baby at home and not pre-natal care. Seán complained to the FSPO that the insurer did not correctly distinguish between normal pre-natal care and the preparation for a homebirth by a midwife. Seán also complained that the insurer's claims process, through its app, gave rise to an unnecessary delay in the assessment of the claim.

The insurer confirmed that Seán submitted a receipt for €700 from a midwife, through its healthcare app, without an accompanying claim form. A claims assessor subsequently contacted the midwife, who confirmed that the date of her visit to Seán's home was in June and the birth of the Seán's daughter did not occur until July. On that basis, the insurer was satisfied that the midwife's charges related to pre-natal services and not to the home delivery of the baby. The insurer explained that Seán's policy did not include pre-natal or post-natal benefits. The insurer stated that the policy benefit for a homebirth was for a normal delivery at home only, and not for any preparations that were required in the home in advance.

The Ombudsman recognised that Seán's policy did not include pre-natal care, a fact that Seán accepted. The Ombudsman acknowledged that the insurer had explained, by email, to Seán that the delivery benefit would only include a normal delivery at home up to a maximum benefit of €3,500 and that it specifically excluded pre-natal or post-natal care.

The Ombudsman noted in the submission made by Seán, that there was a difference between normal pre-natal care and the preparation for a homebirth by a midwife. However, the Ombudsman accepted that the policy and the explanatory email sent to Seán clearly stated that only the delivery of the baby would be covered and that any pre-natal care fell outside the policy benefits.

In respect of the delay in processing Seán's claim, the Ombudsman accepted the insurer's explanation that the app is designed for submitting outpatient expenses only, as opposed to in-patient claims. The insurer confirmed that it could not process the claim until it had received the required claim form from Seán. Seán later acknowledged that he incorrectly submitted the claim through the online app.

The Ombudsman did not accept that there was any wrongdoing by the insurance company in its decision to decline the claim and the complaint was not upheld.

Decision 2021-0029 Read the full decision

Overnight hospital admission deemed not medically necessary

Karola attended a private hospital in March 2018 and was admitted overnight, following an MRI. Karola subsequently received an invoice from the hospital for €170 for the MRI scan and €548 for overnight admission, as Karola's insurer had declined to pay her claim.

Karola provided her insurer with a letter from her consultant confirming that he deemed it appropriate for Karola to be admitted because of significant back pain and tingling in her legs and feet. Karola also confirmed that she had contacted her insurer earlier, on the day she was admitted to hospital, to enquire about her coverage and was told that once it was "medically necessary" for her to be admitted, she would be covered. The insurer later wrote to Karola stating that she was ineligible for cover for the overnight admission as it had been subsequently determined that it had not been "medically necessary" for Karola to be admitted and that the medical services could have been provided as a day-patient or out-patient. Karola complained to the FPSO that her insurer wrongfully declined her claim.

The insurer noted that the service agreement in place with the hospital permitted the insurer to dispute claims of "medical necessity". Having subsequently reviewed the medical notes, the insurer's review team considered that Karola did not meet the criteria for inpatient admission, as the treatment could have been safely carried out as an out-patient, once the acute cause had been ruled out. Given that the MRI had ruled out an acute cause in Karola's case, the insurer was of the view that admission overnight was unnecessary. The insurer confirmed that its decision had also been reviewed by an external consultant.

The Ombudsman noted that Karola's consultant spine surgeon, present at the time in the hospital, was clear that there was a medical reason for the admission, in both his opinion and the opinion of the experienced emergency room consultant. The Ombudsman noted that the MRI ruled out the risk of Karola suffering from an acute cause. However, he also noted that the insurer's external report failed to acknowledge that two medical consultants, who had the opportunity to review Karola first-hand, made the decision to admit her overnight based on her symptoms. Accordingly, the Ombudsman was of the view that the insurer's decision to decline cover was unreasonable.

The Ombudsman deemed it reasonable for Karola to take the view that if her physician deemed the procedure and admission "medically necessary", that the procedure/admission would be covered under the policy. The Ombudsman also found no evidence that the insurer advised Karola it would be the insurer's medical experts who would decide whether the procedure/admission was medically necessary, rather than her attending doctors, which the Ombudsman believed, was crucial information.

The Ombudsman ultimately took the view that the way the insurer had dealt with Karola's claim, fell short of what is required by the Consumer Protection Code. Furthermore, the Ombudsman noted that Karola only became aware of her claim being rejected when she received invoices from the hospital. The Ombudsman noted that far better communication was required from the insurer and was satisfied that it wrongfully declined Karola's claim. The Ombudsman upheld the complaint and directed the insurer to reimburse Karola for the full sum of her costs/expenses minus any required excess and also directed compensation of €500 in light of the inconvenience caused to Karola.



Decision 2021-0140 Read the full decision

Claim for outpatient expenses to be treated as inpatient expenses not upheld

In September 2019, Peter attended a medical clinic abroad for treatment. He was initially treated for approximately 75 minutes in the medical clinic, before he was transferred to a hospital by ambulance and admitted for seven days. The cost of the treatment for the hospital was fully discharged by Peter's insurer. Peter also submitted a bill from the medical clinic worth €850 and was refunded €170, being the amount payable under his policy as an outpatient. Peter held the view that the insurance company incorrectly assessed his time in the medical clinic as outpatient care. Peter requested that the insurance company assess his full insurance claim as an inpatient and refund him the balance of the cost of €680 for his treatment in the clinic.

The insurance company had concluded that because Peter was treated in the clinic before being transferred to hospital for admission, he fell under the definition of an outpatient rather than inpatient, in line with the definition of those terms in the policy booklet.

The insurance company stated that Peter's policy allowed him cover of up to €100,000 for the purpose of inpatient overseas care. The insurer emphasised that to be covered, Peter must have received the emergency care in an internationally recognised hospital. Peter's inpatient stay in the hospital for seven nights was therefore fully covered by his insurer. However, the medical clinic where Peter received his initial treatment confirmed that it did not have any link to the hospital that Peter was subsequently admitted to. It stated that while the medical clinic did have some inpatient facilities, it did not have the necessary facilities to treat Peter and that was why he was transferred to hospital.

The Ombudsman identified that the core issue was whether the treatment at the medical clinic should be categorised as inpatient or outpatient treatment. The Ombudsman noted that Peter did not stay overnight in the medical clinic and that he was treated there, initially and on a limited basis, before being transferred to an internationally recognised hospital for seven nights. The Ombudsman therefore accepted that the treatment of Peter at the medical clinic met the definition of an outpatient under his policy, in that he underwent procedures and medical treatment in the clinic without being an inpatient or a day-case.

The Ombudsman was satisfied that the insurance company correctly assessed Peter's claim for payment of benefits and did not uphold the complaint.

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