An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Financial Services and Pensions Ombudsman publishes Digest of Decisions on private health insurance

Ombudsman highlights the importance of consumers understanding the extent of their health insurance cover and the waiting periods that can apply for new cover, or after an upgrade.

15 November 2022: The Office of the Financial Services and Pensions Ombudsman (FSPO) has published a Digest of Decisions on private health insurance complaints. This Digest provides summaries of decisions issued between 2018 and 2022 and highlights the difficult circumstances experienced by consumers which lead to a complaint to the FSPO.

Commenting on the publication of the Digest, the Financial Services and Pensions Ombudsman (Acting), MaryRose McGovern, said:

"Private health insurance can represent a significant amount of a household's budget, on average being in the order of €1,410 per adult, per year. This insurance 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. Recent research carried out on behalf of the FSPO[1] revealed that 51% of participants reported having private health insurance.

Some consumers who purchase private health insurance are not familiar with their cover or do not understand how waiting periods can affect their ability to make a claim on their policy. As with all financial products, it is so important to understand what you are buying and to be aware that not all insurance policies are the same.

The level of hospital cover and outpatient cover is at all times determined by the type of plan chosen by the consumer. 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. Our recent market research also revealed that 27% of participants who held health insurance felt they had a poor understanding of the cover on their plan, in contrast to 15% who felt they had a very good understanding.

Complaints brought to the FSPO highlight that people are not aware that medical investigations, X-rays or blood tests, which were required before they took out cover, can result in a condition being defined as being pre-existing. The policy holder may not believe that there was a pre-existing condition, because it had not been given a name at the time of the investigations. It is important for consumers to be aware that a pre-existing condition can exist, without a formal diagnosis, and it is the signs and symptoms within the period, which are relevant".

[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.

The Digest highlights the wide range of issues giving rise to complaints concerning private health insurance and the difficult circumstances leading to those complaints. Some examples of directions made by the Ombudsman in the decisions published include:

- Direction to pay a claim of €67,778 and compensation of €2,000 to Debbie who complained that her request for pre-approval to get treatment in another EU country was declined. Debbie's insurer maintained that the treatment was not consistent with a proven form of treatment for her condition, in accordance with the listed criteria in her plan's rules book. The Ombudsman was particularly concerned by the insurer's "manifestly incorrect" assertion that the insurer's 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 need for medical treatment.
- Direction to pay €3,000 to Alice who rang her insurer to confirm cover for her dental work, which was due to cost €7,000. The insurer advised Alice that she would be covered for 70% of the cost of the treatment but failed to advise her that her plan would renew in five days' time, with lower dental benefits. In addition, the insurer paid the benefit to the wrong bank account. The Ombudsman was satisfied that the insurer should have advised Alice that her cover 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. Alice's complaint was substantially upheld.
- Decision to reject a complaint concerning a claim of €10,892 undertaken by Matthew for Robotic Assisted Laparoscopic Surgical Prostatectomy (RALSP). When queried, Matthew's insurance company informed him that he had signs and symptoms of his condition, in the form of a raised PSA before he upgraded 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 since his date of diagnosis was after the date of his policy upgrade, that this should dictate whether the illness was pre-existing or not. The Ombudsman was satisfied that the insurer had correctly applied the terms and conditions applicable to new registrations or renewals when concluding that Matthew's condition preceded his upgrade in cover.
- Decision to reject a complaint concerning Sarah's claim for removal of a dermoid cyst. Sarah suffered from Polycystic Ovary Syndrome (PCOS), which led to an irregular menstrual cycle. Sarah was referred to a gynaecologist for fertility issues related to her irregular cycle and an ultrasound revealed the cyst. When Sarah enquired about her cover, her insurer advised that the date of onset of the symptoms would determine if the condition was pre-existing. Sarah had the surgery, and her claim was declined by the insurer. Sarah maintained it was not a pre-existing condition, as her gynaecologist advised her the cyst was unrelated to her PCOS. However, her insurer declined her claim on the basis that Sarah's symptoms which prompted the ultrasound (being her irregular menstrual cycle), 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 for that condition. The Ombudsman was satisfied that the insurer was

entitled to form the reasonable opinion that the surgery was for a pre-existing condition and was entitled to decline the claim. The complaint was not upheld.

Ms. McGovern added, "*The decisions in this Digest highlight the difficulties that can arise in understanding the complexity around waiting periods and the issues that can occur when seeking approval of cover. 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.*

Health insurance policies will not cover you for every eventuality, so it is worth taking some time now, to familiarise yourself with your cover and its associated waiting periods before you need it. It is important that customers do not wait until they have symptoms to take out private health insurance and then expect to be covered for those illnesses.

Our recent market research showed that of those surveyed who held health insurance, 68% are aware of when their policy is due for renewal. We are approaching the time of year when many people will be thinking about reviewing or renewing their private health insurance, or indeed perhaps switching providers, particularly in light of the current cost of living pressures. It is vital that consumers take some time, before starting the renewal process, to make sure they understand the impact of any decisions they make in upgrading or downgrading their cover".

In addition to publishing the Digest of Decisions, the FSPO's Database of Decisions on www.fspo.ie has the full text of over 1,850 decisions and includes decisions issued up to the end of July 2022. By publishing legally binding decisions and Digests of Decisions, the Ombudsman aims to enhance transparency and understanding of the powers of the FSPO and the services it provides.

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Tá an OSAP ar fáil le hagallaimh a dhéanamh trí mheán na Gaeilge.

Notes to Editor

- In accordance with Section 10(1)(d) of the Financial Services and Pensions Ombudsman Act 2017 (the Act), Ms. MaryRose McGovern was appointed Financial Services and Pensions Ombudsman (Acting), by the Minister for Finance, with effect from 6 February 2022 until such time as the appointment of an Ombudsman is made, under Section 8(1) of the Act, and for not more than 12 months.
- When the FSPO issues a legally binding decision, that decision is subject to a potential statutory appeal to the High Court within 35 calendar days from that date.

- The FSPO does not publish decisions before the elapse of the 35-day period available to the parties to make a statutory appeal to the High Court.
- Decisions which have been appealed to the High Court are not published, pending the outcome of any such Court proceedings.
- The FSPO publishes a list of active statutory appeals on its website.
- 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 FSPO deals with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both. Informal mediation allows a faster resolution. When these early interventions do not resolve the dispute, the FSPO investigates the complaint and subsequently issues a decision that is legally binding on both parties, subject only to an appeal to the High Court.
- The Ombudsman can direct a financial service provider to pay compensation of up to €500,000 to a complainant and/or to rectify the conduct that is the subject of the complaint. There is no limit on the value of the rectification that can be directed.
- Decisions issued by the Financial Services and Pensions Ombudsman are legally binding on both parties and can only be appealed to the High Court. Decisions are available on our Decisions Database.