DRN-4208160

The complaint

Mr G is unhappy with the delay he experienced with CIGNA Life Insurance Company of Europe SA-NV paying his claims. He's also unhappy with the service he received during that time.

What happened

Mr G had private medical insurance with CIGNA. He first brought a complaint to this service in early 2022. It was decided as part of that complaint that CIGNA needed to pay Mr G's claims for his shoulder and back injuries.

This complaint is about what happened after our previous decision and in particular, the delays and reassessment of his spine and shoulder claim. To be clear, I've not considered the merits of the previous case because that was settled separately.

Mr G said it took too long for CIGNA to reassess and pay his claim for his spinal injury. He's also unhappy because he had to resend a lot of information CIGNA already had. Mr G explained he had a similar experience with his shoulder claim because CIGNA took so long to arrange that too. He said CIGNA failed to provide a guarantee of payment to the treating clinic which meant he had to pay the cost upfront and that caused him extreme worry and upset. Mr G also complained about other service-related issues where call backs from managers went unfulfilled alongside other subsidiary customer service problems.

CIGNA acknowledged there were errors made in handling the claim. It also agreed the service offered to Mr G was poor, in particular, requests to speak to managers went largely unfulfilled, as too did many of his emails.

Our investigator upheld Mr G's complaint in part. He said CIGNA hadn't caused any unreasonable delays assessing the spinal claim, however, there were delays settling it. He acknowledged CIGNA made an error when it attempted to pay Mr G which caused unnecessary delays.

Our investigator also said CIGNA hadn't caused any unnecessary delays assessing Mr G's shoulder claim. He said it'd sent the surgery approval to pay all reasonable costs for the treatment well before the surgery was due to take place. However, the hospital decided to verify that document the day before Mr G's intended treatment only for CIGNA to be unable to verify its authenticity. And so, Mr G had to pay those costs and claim them back later. Our investigator recommended CIGNA pay Mr G £500 for the overall distress and inconvenience caused.

CIGNA agreed with the recommendation, but Mr G didn't. In summary, Mr G said the compensation isn't enough given the severity of the errors and the impact they had. Mr G said this is against a backdrop of constant failures by CIGNA and even when instructed to carry out remedial action for the previous issues, it's still unable to get things right. And so, it's for me to make a final decision on whether the compensation recommended is fair.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I've decided to uphold it for the same reasons explained by our investigator. I also think the investigator's recommendation of £500 compensation for the overall distress and inconvenience caused is fair. I say that because I consider the issues Mr G's experienced to have caused him considerable and significant distress and so this award is fair in the circumstances. I'll explain why.

The spinal claim

On 20 September 2022 CIGNA agreed it would reassess Mr G's claim for spinal surgery. But it wasn't until 7 November 2022 that it agreed to pay the claim. And so, I've considered what happened in those seven weeks and whether the time taken to reach that decision was reasonable. I should also highlight that the Insurance Conduct of Business Sourcebook (ICOBS) says CIGNA must consider claims promptly and fairly and not reject a claim unreasonably.

There was a considerable amount of correspondence between Mr G and CIGNA during that time. Our investigator didn't think it was unreasonable for CIGNA to ask for the information it did because of the complexities involved with this case. I must say I agree with that statement. I say that because I'm aware of the long-standing history between both parties and there's been a wealth of information exchanged between the parties over the past two years.

I note our investigator initially thought the recent submissions included information that hadn't previously been shared with CIGNA, but I disagree. I didn't see any new information in those submissions. But that still doesn't mean the delays were unreasonable, or unnecessary. I say that because I think given the length of time this issue was outstanding, it's fair that CIGNA review the medical evidence and the history of events so it could fairly determine whether to accept the claim.

Mr G provided all the information requested on 4 November and a claims decision was given three days later. I don't consider that timeframe to be excessive.

There were more serious delays with settling this claim. It wasn't paid until 13 January 2023 which was a long time for Mr G to be without his money. CIGNA explained the reason for the delay was because it'd made errors instructing the funds to be paid. Having carefully considered this, I'm satisfied that was the case because it'd failed to correctly carry out the SWIFT instruction mandate on six occasions. Mr G's suggested a more sinister explanation that CIGNA made the mistake deliberately to cause him further upset, but I've not seen any evidence that would support that argument and I'm not persuaded CIGNA would intentionally make that error.

Mr G made many attempts to try and resolve this issue and I note he'd repeatedly requested call backs from managers that went unfulfilled. I thought that was a particularly poor way to treat Mr G given the duration of the issue. I also noted that of 11 emails requesting this, it took four emails before a manager acknowledged his concerns. The manager then continued to ignore Mr G's subsequent emails asking for help. I thought that was unfair and I can see how that would have caused Mr G considerable and significant distress and worry.

The shoulder claim

On 20 September, CIGNA agreed to reassess Mr G's shoulder claim. He wanted to arrange surgery for when he was back in the UK and he requested CIGNA provide a guarantee of payment to his chosen hospital in November 2022. CIGNA was unable to do that because the treating hospital couldn't agree to a fixed price. So, instead, CIGNA sent a letter saying it'd cover all reasonable treatment costs associated with the claim – which I thought was fair in the circumstances.

The day before the treatment was due to take place, the hospital decided to verify that letter with CIGNA, however, it was unsuccessful. The advisers at CIGNA didn't have prior knowledge of Mr G's case and I think this caused some confusion. The hospital discussed this with Mr G and said it'd need to cancel the planned treatment as it couldn't verify the document. I agree this must have been significantly worrying for Mr G, given he'd waited such a long time for the surgery, only to find the possibility of it being cancelled because CIGNA couldn't verify its letter of authorisation.

I must stress that I don't think this was in anyway a deliberate attempt to cause additional stress, or to try and effectively get out of its commitment to pay for the surgery. There's no evidence to support that argument. I'm satisfied this was simply poor service, perhaps exacerbated by the lack of a case ownership structure, which undoubtedly caused the confusion over the letter authorising CIGNA's liability over reasonable treatment costs. Mr G paid the hospital and I note those costs were quickly returned to him. But I still acknowledge the significant distress and inconvenience this caused.

Putting things right

Overall, things didn't go well for Mr G for the reasons I've explained. I note Mr G didn't renew his policy with CIGNA citing the continued issues as the main reason for that. I agree the service Mr G received was poor since September 2022 for all the reasons I've explained. I consider the inconvenience to be significant and at times, considerable, which is why I agree with our investigator that £500 compensation in these circumstances is fair.

I note Mr G's made arguments that compare CIGNA's net worth and the compensation awarded. I understand the connection he's making here, but I'm not persuaded it means I should increase the award. I say that because it's not for the ombudsman service to make punitive awards, rather, it's to assess the impact CIGNA's errors had on Mr G and make an award. I consider the impact to be considerable and £500 is a fair award in these circumstances.

My final decision

My final decision is that CIGNA Life Insurance Company of Europe SA-NV must pay £500 compensation for the overall distress and inconvenience caused to Mr G.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 29 August 2023.

Scott Slade
Ombudsman