DRN-4561811

The complaint

Ms L is unhappy with the way in which Vitality Health Limited has handled claims made on a group private medical insurance policy ('the policy') including delays and failing to provide updates.

What happened

In July 2022, the policyholder, switched its private medical insurance from an insurer I'll refer to as 'A' to Vitality.

In September 2022, Ms L made a claim on the policy to cover the cost of cognitive behaviour therapy (CBT). She forwarded a referral letter to Vitality together with a signed self-declaration form which detailed the condition/symptoms as 'depression'. Vitality accepted the claim and approved eight sessions.

In November 2022, Ms L contacted Vitality for it to authorise additional sessions as she'd had eight sessions. By that stage, Vitality had paid for four of the sessions.

Vitality considered Ms L's request and decided to request information from Ms L's GP because it wanted to ensure that certain questions about Ms L's health and medical history had been answered correctly when switching to the policy.

In or around April 2023, Vitality concluded that it wasn't unreasonable for Ms L not to have listed any details in response to the question around whether Ms L had consultations or treatment for any psychiatric related condition in the last three years. It said the claim would now be assessed in the normal manner.

In September 2022, Vitality also received a referral letter for Ms L in respect of back pain. She wanted to see an osteopath. Vitality again considered whether Ms L's back issues pre-dated the start of the policy and whether questions about her medical history had been properly answered when taking out the policy.

Ms L also made claims to be referred to a dermatologist and to a neurologist as she was experiencing headaches. Both these claims were out on hold whilst the claims for further CBT sessions and osteopathy for Ms L's back pain were being investigated.

In April 2023 - after its' investigations were completed, and it had determined that the application form (with answers to medical questions) completed on behalf of the policyholder by Ms L was correct – Vitality concluded that it would arrange for its representative to contact Ms L to discuss her claims further.

Prior to this, Ms L brought her complaint to the Financial Ombudsman Service. And in May 2023, Vitality issued a final response letter. It accepted that there had been unreasonable delays in assessing her claims and offered £25 compensation.

Our investigator didn't think that fairly and reasonably reflected the distress and inconvenience Ms L experienced. He recommended Vitality pay Ms L £350 compensation.

Vitality disagreed but it did offer £200 compensation.

Our investigator didn't think this was sufficient and Ms L's complaint was passed to me to consider everything afresh and decide.

I issued my provisional decision earlier in January 2024, explaining in more detail why I was also intending to uphold Ms L's complaint, provisionally directing Vitality to pay £350 compensation for distress and inconvenience.

An extract of my provisional decision is set out below:

……..

Vitality has an obligation to handle insurance claims fairly and promptly. And it mustn't unreasonably decline a claim.

Ms L has raised more recent issues with our investigator such as Vitality not reimbursing her in full for the up-front costs she was required to pay for treatment whilst her claims were being investigated, and that it hasn't provided her with a full breakdown of what's been paid and its calculations, as requested by her.

However, I'm only considering what happened up to the date of Vitality's final response letter dated 16 May 2023 (which was a follow up its final response letter dated 23 December 2022).

The claim for CBT

Although Vitality had concerns about whether certain medical questions had been answered correctly in relation to psychiatric related conditions in respect of Ms L when looking to switch the policy to Vitality, this only arose after Ms L had completed eight sessions of CBT which Vitality had authorised.

By that stage, it had paid for four sessions, leaving Ms L being chased by the CBT therapist for the balance. I'm satisfied that Ms L wasn't kept updated about likely timescales. And I think this made it difficult to know when, if at all, further CBT sessions would be covered – whilst CBT was ongoing. I'm satisfied she wasn't provided with a comprehensive update as to the next steps until 15 December 2022 – almost three weeks after requesting authorisation for further CBT sessions. I don't think that's reasonable in the circumstances.

And in its final response letter dated 23 December 2022, Vitality accepts that Ms L was waiting too long for her calls to be answered and that it had agreed to initially cover the cost of eight CBT sessions but that wasn't guaranteed now.

Vitality is entitled to look to verify claims and it's not uncommon for private medical insurers to request historical medical records (such as GP notes) before doing so, particularly when the policy has continued with another insurance provider with the same underwriting terms that previously applied, as is the case here.

Although the CBT therapist was able to reasonably promptly confirm that they hadn't met with Ms L in the three years leading up to the policy being applied for, there were significant delays obtaining the GP records. I don't think I can reasonably hold Vitality responsible for this delay, and I'm satisfied that Vitality was proactively trying to chase this information. I've seen evidence that they were regularly chasing the GP practice between January and March 2023, after the initial request was made to the GP in December 2022.

I'm also satisfied that Vitality reasonably promptly considered the GP notes upon receipt against the questions asked when switching the policy to Vitality and considered the issue internally.

The claim for back pain, dermatologist and neurology referral

In response to our investigator's view, Vitality accepts that there was a delay in reviewing the claim for back pain. However, if this claim had been reviewed more promptly, it says it wouldn't have been authorised until the claim for CBT had been internally investigated. And those investigations didn't conclude until April 2023.

However, based on everything I've seen to date, had Vitality more promptly considered the claim for back pain, I think treatment for this is most likely to have been approved before Vitality becoming aware of potential issues with the CBT claim – and the question answered about psychiatric related conditions when switching policies.

So, I think delays in having treatment for back being authorised would've been upsetting and frustrating for Ms L.

However, overall, I don't think Vitality unreasonably delayed making a claims decision about whether to cover the dermatology or neurology referrals, which were made whilst the internal investigation into whether the related psychiatric condition question had been answered correctly around the time of switching the policy to Vitality.

Communication and updates

I do think there was a general lack of communication on Vitality's part, including failing to update Ms L and to let her know why her claims couldn't be progressed, pending the outcome of the internal investigation into whether medical questions were answered correctly when switching policies. And I think this would've been frustrating, at an already difficult and confusing time for Ms L.

Not providing all call recordings

It isn't disputed that in December 2022, Ms L asked for all call recordings she'd had with Vitality. And, upon receiving the sale calls, in the middle of January 2023, she said she hadn't received recordings of the calls relating to conversations around the CBT claim she had with Vitality's representatives.

Our investigator concluded that these hadn't been provided to her. In response to the view, Vitality hasn't provided any convincing evidence that they were provided – or promptly. I'm satisfied Ms L chased for these, and I think this caused her unnecessary frustration and inconvenience.

Distress and inconvenience

I'm satisfied that there were occasions when Ms L wasn't updated as often as she could've been about the progress of the internal investigation, likely timeframes and how this impacted the progress of her other claims.

I accept this would've been worrying, confusing and upsetting for her. I also think she was put to unnecessary trouble having to chase Vitality for updates, and she was waiting longer than she should reasonably have had to speak to a representative of Vitality for updates. I think £350 compensation fairly reflects the distress and inconvenience she experienced.

……

I invited both parties to provide any further information in response to my provisional decision they wanted me to consider.

Vitality said it thought the proposed compensation sum was excessive in the circumstances but had nothing further to provide.

Ms L explained why she felt she should receive more compensation than I provisionally directed. She also said:

- she'd never had "depression or any other mental health illness".
- Vitality still haven't paid some of the CBT costs.
- she'd like Vitality to provide a breakdown of all costs paid to date.

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.

That includes the further comments received since the date of my provisional decision. Having done so, I see no compelling reason to depart from my provisional decision.

Both parties are unhappy with the compensation amount I provisionally directed Vitality to pay Ms L. However, for reasons set out in my provisional decision, I'm satisfied £350 fairly reflects the distress and inconvenience experienced by Ms L because of Vitality's failings in this case.

I appreciate that Ms L says she never had depression. But I'm only reflecting what is stated on her self-declaration form, signed by her in September 2022.

Further, she says that Vitality still haven't paid some of the CBT costs and she'd like it to provide a breakdown of all costs paid to date. As explained in my provisional decision, I'm only considering what happened up to the date of Vitality's final response letter dated 16 May 2023 (which was a follow up its final response letter dated 23 December 2022).

If Ms L is unhappy with anything which occurred after mid-May 2023, she's free to raise her further concerns with Vitality in the first instance.

So, for reasons set out in provisional decision (which forms part of this final decision), I uphold Ms L's complaint.

Putting things right

I direct Vitality to pay £350 compensation to Ms L. Vitality can deduct from this amount the sum of £25 offered in its final response letter, if this has already been paid.

My final decision

I uphold this complaint to the extent set out above. I direct Vitality Health Limited to put things right as set out above

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms L to accept or

reject my decision before 23 February 2024.

David Curtis-Johnson
Ombudsman