DRN-4808783

The complaint

Miss S complains about the way that AXA PPP Healthcare Limited has handled a claim she made on a group private medical insurance policy.

What happened

The detailed background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Miss S was insured under her employer's group private medical insurance policy. Cover started under the policy in November 2022 and was provided on moratorium underwriting terms. This meant that AXA wouldn't pay for claims caused by any conditions Miss S had experienced in the five years before cover under the policy began, unless Miss S had been symptom-free for a continuous two-year period following the start of cover.

In January 2023, Miss S called AXA to make a claim for acupuncture and osteopathy. That's because she said she'd strained a muscle during recent travel and because she wanted treatment for a hiatus hernia. During the call, Miss S initially told the call handler that the hiatus hernia had been diagnosed in March 2022, following an endoscopy. This meant Miss S had been diagnosed with a hiatus hernia only a few months before cover began - which would therefore be excluded by the terms of the moratorium. However, later during the call, Miss S said the treatment was for new symptoms of pain and bloating which had been present for around two-three months. AXA let Miss S know it would need further medical evidence in the form of medical information forms (MIFs) to allow it to assess her claim.

Miss S provided AXA with a referral letter from her GP, which stated that she'd previously been investigated by 'gastro'; diagnosed with hiatus hernia; prescribed antibiotics for small intestinal bacterial overgrowth; and had been prescribed PPIs for three months with no improvement in reflux symptoms.

However, the same GP later completed two MIFs – one for Miss S' gastric symptoms and one for her muscle pain. Both MIFs stated that Miss S' symptoms had begun in early January 2023. On that basis, Miss S' claims were approved.

Miss S began treatment and submitted invoices. While the claim was ongoing, AXA informed Miss S that it shouldn't have covered the claim for gastric treatment and that the treatment she'd received wasn't covered. However, it later agreed to cover the invoices she'd already submitted due to a lack of clarity about what had been accepted as covered.

Subsequently, in March 2023, the GP sent new MIFs, including for a referral to gastroenterology. The GP listed Miss S' symptoms and included acid reflux, slow digestion and bloating. Again, the GP stated that those symptoms had begun in early January 2023. Based on the MIFs, AXA agreed that Miss S could see a gastroenterologist and undergo diagnostic testing.

Following testing, Miss S' gastroenterologist recommended that she undergo hypnotherapy treatment. So, in April 2023, Miss S claimed for this treatment. AXA told Miss S that it would

only cover hypnotherapy in cases of diagnosed IBS if treatment had been ongoing for more than one year. During the call, Miss S told the call handler that she'd undergone an endoscopy in March 2022, that she'd been prescribed PPIs and had been treated overseas. As this accorded with the information Miss S had originally given AXA and with the first GP referral letter, it concluded it needed more medical evidence to assess whether or not the claim was covered.

Miss S ultimately provided consent for AXA to obtain medical information relating to her gastric issues, although she says she didn't agree to it obtaining information about her muscle strain. AXA obtained information from Miss S' treating practitioners. It concluded that her symptoms had existed prior to the policy beginning and was therefore excluded from cover. And it also concluded that Miss S had provided inaccurate symptom reporting. It said that as Miss S' claim had been found to be partly or wholly fraudulent, the policy terms entitled it to claw back any monies it had paid for the gastric claim. So it required Miss S to repay around £3600.

Unhappy with AXA's position, Miss S asked us to look into her complaint. Briefly, she was unhappy with the handling of the claim; that AXA had asked for medical evidence unrelated to her gastric claim, and that it had previously approved her claim more than once before ultimately declining it. Miss S also said she hadn't experienced symptoms of the condition causing the claim previously – she said she'd developed symptoms as a result of bugs she'd picked-up while travelling after cover began.

Miss S had made complaints about AXA's handling of the claim throughout the life of it. AXA issued final responses to some of those complaint points in January 2023 and in March 2023. But Miss S hadn't brought a complaint to our service until 28 November 2023 – which was more than six months after the final response letters of January and March 2023 were issued. So the investigator concluded that Miss S had made those complaint points too late under our rules.

After the investigator made her findings on what aspects of Miss S' complaint we could help with, she went on to consider whether she thought AXA had acted fairly. In brief, she concluded that it had been fair for AXA to rely on the evidence to conclude that Miss S' symptoms had pre-existed the cover start date and therefore, weren't covered. She thought Miss S had given AXA contradictory information about her symptoms. So she considered AXA was entitled to require repayment of its outlay in relation to Miss S' gastric claim. She felt AXA had asked for reasonable information. And she wasn't persuaded that even if AXA had wrongly asked for evidence about the muscle strain claim, this had led to Miss S suffering any detriment.

Miss S disagreed. In summary, she felt the investigator had been biased and hadn't taken relevant evidence into account. She maintained that she hadn't had a previous diagnosis or symptoms.

The complaint's been passed to me to decide.

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, whilst I'm very sorry to disappoint Miss S, I don't think AXA has treated her unfairly and I'll explain why.

First, I'd like to reassure Miss S that whilst I've summarised the background to this complaint and her detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

It's also important that I make the parameters of this decision clear. Our investigator explained to Miss S why we couldn't look into any complaint point which AXA had dealt with in any of its final response letters which pre-dated 28 May 2023. That's because under our rules, a consumer must bring a complaint to us within six months of the date of a financial business' final response letter, unless the delay was due to exceptional circumstances or unless the financial business consents to us looking at it. In this case, AXA's letters made it clear that if Miss S brought her complaints to us more than six months after the date of each letter, it wouldn't consent to us looking at them. The investigator was satisfied that some of Miss S' complaint points were brought too late, as Miss S hadn't complained to us until 28 November 2023. And she didn't think exceptional circumstances applied which had prevented Miss S from complaining to us in time.

Our investigator explained that if Miss S disagreed with her findings on our jurisdiction, she'd need to ask for an ombudsman to make a decision on that particular point. But Miss S didn't do so by the deadline the investigator gave and so the investigator proceeded to consider the complaint points she *did* think had been brought in time. For completeness though, I'd add that I agree that we can only look into Miss S' complaint points which post-date 28 May 2023; that AXA's final response letters clearly set out referral rights to our service; that they made it clear that it wouldn't consent to us looking at complaints brought after that date, and that I don't think exceptional circumstances applied which would've prevented Miss S from bringing those complaint points to us within six months of the relevant letters.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations and regulatory principles, when deciding whether I think AXA handled Miss S' claim fairly.

I've first considered the policy terms and conditions, as these form the basis of Miss S' employer's contract with AXA. Miss S' cover was provided on moratorium terms. This means:

'You won't have cover for treatment of medical problems you had in the five years before you joined until:

- *You've been a member for two years in a row; and*
- *You've had a period of two years in a row since you've joined that have been trouble free.'*

AXA defines a pre-existing condition as follows:

'Any disease, illness or injury that:

- *You have received medication, advice or treatment for in the five years before the start of your cover; or*
- *You have experienced symptoms of in the five years before the start of your cover; whether or not the condition was diagnosed.'*

The moratorium clause is also clearly set out on Miss S' policy certificate. And in my view, AXA has made it sufficiently clear that it won't cover any conditions a policyholder has had in the five years before their cover started, even if there hasn't been a formal diagnosis.

Page 50 of the contract sets out 'What happens if you break the terms of the plan?'. It says:

'If you break any terms of the plan that we reasonably consider to be fundamental, we may do one or more of the following:

- *refuse to pay any of your claims,*
- *recover from you any loss caused by the break,*
- *refuse to renew your membership to the plan,*
- *impose different terms to your cover on the plan,*
- *end your membership of the plan and all cover immediately*

If you (or anyone acting on your behalf) claim knowing that the claim is false or fraudulent, we can refuse to pay that claim and may declare your membership of the plan void, as if it never existed. If we have already paid the claim we can recover what we have paid from you.

If we pay a claim and the claim is later found to be wholly or partly false or fraudulent, we will be able to recover what we have paid from you.'

In this case, AXA ultimately assessed the available evidence and concluded that Miss S had provided it with inaccurate information about her gastric symptoms. And so not only did it decline her claim under the terms of the moratorium, it also told Miss S that it required repayment of its outlay for her gastric costs. So I've next considered the available evidence to decide whether I think this was a fair decision for AXA to make.

Like the investigator, I've listened to calls which I consider to be material to the complaint. The first of those calls took place in January 2023 when Miss S first made the claim, including treatment for a hiatus hernia. During that call, Miss S told AXA that she'd had an endoscopy and had been found to have a hiatus hernia in March 2022. She also said she'd had symptoms of pain and bloating for two-three months. Under the terms of the moratorium, Miss S' claim for hernia treatment would have been excluded, given she'd had a diagnosis around eight months before cover began.

The GP's first referral letter of January 2023 stated that Miss S was experiencing symptoms including poor digestion and bloating. The letter said: '*investigated by gastro…given (antibiotics) for SIBO but symptoms have not improved. Diagnosed with hiatus hernia on OGD – given PPI for 3 months but reflux symptoms have not improved.'* This letter indicates that Miss S had already been investigated, diagnosed with a hernia and had previously taken medication for three months which hadn't resolved things. This too would indicate that Miss S' gastric claim wasn't covered by the policy terms.

However, Miss S later obtained further MIFs from the GP who'd written the January 2023 letter which stated that her gastric symptoms hadn't begun until early January 2023. This corresponded with Miss S' testimony that she'd developed symptoms as a result of bugs she'd picked up while travelling after the cover had begun. It was on this basis that AXA went on to accept Miss S' referral to gastroenterology and for diagnostic testing.
It was following that referral that Miss S got back in touch with AXA to ask for hypnotherapy to be covered. This call took place in April 2023. During the call, Miss S again referred to having had an endoscopy in March 2022, that she'd been treated overseas and had been given PPIs. As this mirrored what Miss S had told AXA at the first registration of her claim and directly contradicted what she'd later said, I think it was fair for AXA to decide it needed further medical evidence to fully assess the claim. Nor do I think that by requesting this information and asking for Miss S' consent, AXA was unfairly targeting her in any way.

The medical evidence provided from the gastroenterologist says that Miss S' symptoms included bloating and acid reflux. They stated that Miss S had *'tried PPIs but not recently.'* This would support that Miss S had experienced gastric symptoms previously and would tally-up with what she'd told AXA at the outset.

Records from one of Miss S' treating practitioners, dated April 2023, showed that she'd been diagnosed with a hiatus hernia 12 months previously.

Test results dated April 2023 state that the clinical indication was *'large hiatus hernia diagnosed on external OGD.'* Again, this corroborates what the GP wrote in their initial referral letter of January 2023.

And in May 2023, another treating specialist wrote that Miss S had *'a history of excessive bloating and gas.'* And that Miss S had '*previously been diagnosed with gastroparesis.'* It isn't clear whether the letter indicates that Miss S had historically experienced these symptoms or whether it referred to her more recent history. However, again, I think the letter is broadly supportive that Miss S had been experiencing ongoing symptoms of the condition causing the claim.

Miss S maintained to AXA that despite what she'd said in the calls of January and April 2023, she hadn't had previous symptoms or signs of gastric issues. I appreciate Miss S says she was asking hypothetical questions in April 2023, but while this may have been the case, I think it was reasonable for AXA to conclude that Miss S was telling it about a past diagnosis and investigations.

I'm not a medical expert and so it wouldn't be appropriate for me to make a clinical finding. Instead, I've relied on the medical evidence I've been provided with to decide whether I think AXA acted in a fair way. It seems to me that the majority of the medical evidence and indeed, some of Miss S' testimony, indicates that at least some of Miss S' symptoms existed in the year before the cover began. So it seems to me that her gastric claim is squarely caught by the terms of the moratorium. And that therefore, her claim isn't covered by the terms of the policy.

AXA has already paid out over £3600 for Miss S' gastric claim. But if it had had an accurate picture of Miss S' symptoms over the course of the claim, it would never have agreed to cover it. And I don't think it was unfair for AXA to conclude that Miss S had reported her symptoms to it inaccurately during the life of the claim. So I find it was reasonably entitled to conclude that Miss S had broken the terms of the plan and therefore, to require her to repay its outlay for the gastric claim, in line with the policy terms.

Miss S has concerns that AXA unreasonably delayed the claim. While I acknowledge it took some months to make a final claims decision, I don't think this was down to any error on the part of AXA. Instead, I don't think it could make a decision until it had all of the information it needed. I appreciate Miss S feels AXA shouldn't have asked for evidence from practitioners from whom she'd received treatment for muscle pain and that she hadn't consented to it doing so. I understand Miss S has made a new complaint to AXA about that issue, which she told us it's looking into, although it seems this issue was previously raised with AXA as part of this complaint. In my view though, in the round, AXA didn't act unreasonably by requiring medical evidence from Miss S' treating practitioners to assess whether or not the claim was covered. And I think the medical evidence I've set out above provided enough grounds for AXA to both decline the gastric claim and require reimbursement of its costs. It's open to Miss S to complain to the Information Commissioner's Office if she feels there has been a specific breach of data protection laws and regulations.

Overall, while I sympathise with Miss S' position and I'm sorry to hear she has been unwell, I

don’t find that AXA has done anything wrong.

My final decision

For the reasons I’ve given above, my final decision is that I don’t uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Miss S to accept or reject my decision before 22 August 2024.

Lisa Barham
Ombudsman