DRN-5614490

The complaint

Mr P is unhappy that HMCA Insurance Ltd (HMCA) mis-sold a private medical insurance policy.

What happened

The details of this complaint are well-known to both parties, so I won't repeat them again here in full.

Mr P had private medical insurance from January 2002 with a different provider.
In January 2022, Mr P was looking to change his provider and contacted HMCA. Having considered the options provided by HMCA, he decided to take out the policy which started on 11 February 2022.

In April 2024, Mr P submitted a claim for a hip and knee problem – both on the right side. He'd been diagnosed with arthritis and needed to have surgery. HMCA paid for the cost of the surgery up to the benefit limits and Mr P was left to pay a shortfall.

Mr P made a complaint to HMCA. In summary, he said the policy has been mis-sold for the following reasons:

- He now has to pay a shortfall which has left him in a worse position than if he'd stayed with his previous provider.
- Following his treatment, HMCA will no longer cover him for osteoarthritis but agreed to cover him for his right knee. He questions why HMCA offered him the cover in the first place as it was aware he already had one partial knee replacement.
- He wasn't informed of the requirement or expectancy to pay upfront for treatment.
- He's unhappy with the way the product is marketed by HMCA, comparing itself with other leading providers. HMCA accepted it had fallen behind with cost reviews with its service providers. So, it made a small additional payment up to the benefit based on one illustration of a similar operation. Mr P said he would have expected to see an in-depth research and analysis.

HMCA responded and said it didn't think the policy had been mis-sold or that Mr P had been misled.

Mr P brought his complaint to this service. Our investigator didn't think that HMCA had acted unfairly. She said HMCA had provided sufficient information about the policy to enable Mr P to make an informed choice and she didn't think the policy was mis-sold to him.

Mr P disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me to make a decision.

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.

I fully appreciate Mr P's strength of feeling on the matter and I want to reassure him that I've seen and considered the detailed submissions he has provided about his complaint. But it is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr P. Rather it reflects the informal nature of our service, its remit, and my role in it.

Based on what I've seen and heard, this was a non-advised sale. The relevant rules and industry guidelines say that HMCA needed to ensure that Mr P was given enough information that was clear, fair and not misleading so he could decide if the policy was right for him.

Did HMCA provide enough information so Mr P could decide if the policy was right for him?

I've considered the information HMCA provided to Mr P at the time and during the sale.

An initial enquiry pack was sent to Mr P on 7 January 2022. This included (amongst other information) a letter, a brochure providing details of the benefits available, a description of the benefits and an Insurance Product Information Document (IPID).

After Mr P had called HMCA and agreed to take the policy out, on 20 January 2022, he was sent a welcome letter and documents relating to his policy. This included the description of benefits document, the IPID which provided a summary of the policy and informed Mr P of the 14-day cooling-off period and cancellation rights in case the policy didn't meet his needs. HMCA also sent Mr P a hospital list. I note that an endorsement was placed on Mr P's policy. This stated that the benefit was payable in respect of treatment for any acute condition which originated after 1 January 2002.

I understand in between 7 January 2022 and 20 January 2022, Mr P had some questions about the cover provided on the policy, so he called HMCA. I've listened to these calls. Having done so, I'm satisfied that HMCA provided answers to Mr P that he'd queried. And based on the information he'd been provided, in writing and verbally, he decided to take out the policy. I note Mr P said in his submission to this service that, at the time, the policy was competitive compared to his previous policy and after having considered his options, he decided to join the scheme. He also said throughout the literature provided by HMCA and conversation with the agents, he was happy the policy met his needs until he had to make the claim.

Having considered the above information HMCA provided to Mr P, I think the information was sufficiently clear, fair and not misleading and in line with the requirements of the sale being non-advised. I appreciate that in hindsight Mr P feels the policy was mis-sold. However, as the sale was non-advised, the test here is whether he was given sufficient information that was clear, fair and not misleading. Mr P was required to make an informed decision, and I think based on what HMCA provided and what he's said about what happened at the time of the sale, he was able to make the choice to go ahead and take out the policy. I'm satisfied the information provided was sufficient.

I'll go on to consider Mr P's specific points he's raised in relation to why he thinks he's been mis-sold the policy. Mr P has raised a number of points but as I've said above, I've focussed on the heart of the matter rather than responding to each and every point raised.

Mr P now has to pay a shortfall

Mr P said he expected a small shortfall of around 5% of the total cost of his treatment. But the shortfall he's now having to make up has left him in a worse position than if he'd stayed with his previous provider.

There is a discussion about the shortfall on the call dated 10 January 2022. The advisor provided an example of what could be expected for a knee replacement claim. She said HMCA covered around 84% of the total cost of the treatment. I'm not persuaded that HMCA mis-informed Mr P to think that the shortfall would be in the region of 5%. And HMCA also said that costs can vary depending on the treating consultant and the hospital as they're not always consistent.

It's clear that Mr P accepted there would be some shortfall but the level he's had to bear is what he's unhappy about. I appreciate this is difficult. The policy doesn't provide a precise percentage as the cost of treatment would depend on the type of treatment, the hospital and the fees charged by the treating doctors – and this would further vary depending on the claim type itself. But I've also considered that HMCA did apply the increase to the benefits as if a market analysis had taken place for his given situation, as the example the advisor gave was from a couple of years before this.

Mr P highlighted to HMCA that a market review or analysis hadn't taken place and therefore its benefit levels didn't reflect the costs on his claim. As HMCA increased the benefit levels following Mr P raising this issue, I think the action HMCA took to correct this, in his situation, is fair and reasonable. I'm not persuaded that HMCA mis-informed Mr P to think that the shortfall would be as low as 5%. And HMCA also said that costs can vary.

Following his treatment, HMCA will no longer cover him for osteoarthritis but agreed to cover him for his right knee.

Mr P questions why HMCA offered him the cover in the first place as it was aware he already had one partial knee replacement.

I understand Mr P had informed HMCA he'd had partial surgery to his left knee, and he'd need surgery on the other half at a later date. Based on the information Mr P provided on the call, he was advised his left knee wouldn't be covered.

This was based on the policy term 2.29, which states:

> *'Where previous treatment has been received by the member for any joint, either before they became a member of the scheme or since joining it, no benefit will be payable under this policy in the case of any revision or repeat treatment to that joint.'*

HMCA explained that an endorsement wasn't added for arthritis as the previous provider had not applied it prior to the transfer. The cover was continuous when Mr P transferred over. An exclusion was applied for Mr P's left knee however based on the above term 2.29. Mr P had previous treatment to a joint (his left knee) and therefore no benefit would have been payable for this. HMCA's explained based on its underwriting criteria, arthritis was only added after Mr P made this claim as he had to have the surgery. So, it was the condition itself that wasn't covered from this point.

Osteoarthritis is considered a long-term illness in line with the policy terms and conditions. And HMCA has said, its policy isn't to endorse specific joints but the condition in its entirety. So, any future claims where the root cause is osteoarthritis would be excluded.

This is confirmed in term 3.3.2:

'When a condition is first diagnosed (and did not exist prior to enrolment) benefit will be provided for such diagnosis and any necessary treatment for one initial episode only. Subsequent treatment is not covered. When these circumstances occur, the Insurer will issue an appropriate endorsement to the certificate. The Insurer provides a discretionary Long-Term Illness Grant which can be made available to those with a Long-Term Illness to assist transition to NHS care.'

I think the explanation HMCA has given as to why Mr P was offered cover is fair and reasonable and in line with the policy terms and conditions. Mr P has questioned HMCA's underwriting guidance and the evidence to support this. But this isn't something that was within Mr P's initial complaint to HMCA or addressed within. Therefore it's not an issue I can comment on further.

And as osteoarthritis is now added as an endorsement since Mr P made a claim, the condition wouldn't be covered under the policy. My understanding is that the right knee would be covered where the root cause is not osteoarthritis.

I'm satisfied that 3.3.2 is set out clearly in the policy terms and conditions. The sale was non-advised and therefore the requirement for HMCA was to ensure the information was clear, fair and not misleading. Based on this information, Mr P had to make an informed decision about whether he wanted to take the policy out. So, I don't think the advisor needed to have informed Mr P on this specific term on the telephone.

Mr P wasn't informed of the requirement or expectancy to pay upfront for treatment.

When Mr P took out the policy, he was sent a number of documents giving information about the policy, within the enquiry pack and the welcome pack. A question-and-answer document was sent to Mr P. There was a question that asked whether HMCA would pay the specialist directly and the answer stated that HMCA can pay the specialist directly or it can reimburse the member. In the '*Claim guide for You and Your Doctors',* under the section '*When you require treatment'* it states: '*Many hospitals offer reduced charges for patients that 'self-fund' their treatment. You may wish to consider this option as a way to control the cost of your treatment, claiming the authorised benefits from HMCA after your treatment.'*

I've also considered that in July 2024, HMCA notified Mr P of the options of either self-paying for the treatment or as an insured patient.

I'm not persuaded therefore that Mr P wasn't informed of the expectancy to pay upfront for treatment. I don't think this was a requirement but simply an option. Whilst this may be different to other policy providers, I can't see that HMCA didn't inform Mr P of this. This information was provided at the time of the sale as well as when he made the claim.

Market review

Mr P is unhappy with the way the product is marketed by HMCA, comparing itself with other leading providers. He said HMCA accepted it had fallen behind with cost reviews with its service providers. So, it made an additional payment up to the benefit based on one illustration of a similar operation. Mr P said he would have expected to see an in-depth research and analysis.

It's not within the remit of this service to direct HMCA to conduct an in-depth market research of its costs. And I can't comment on this as its solely a commercial decision that's made by the business and this service can't get involved.

I have however looked at how HMCA handled Mr P's query regarding whether a market review had taken place. HMCA responded and said a review had taken place couple of years ago so was a little outdated. Therefore, it applied the claim so that the benefit limits increased. The effect of this was an increase of the limits on Mr P's claim, and this resulted in a smaller shortfall. I'm satisfied this was also in line with what the advisor had said to Mr P that HMCA would pay a cost of treatment at around 84%. I think HMCA acted fairly and reasonably in applying this to Mr P's individual claim.

HMCA also paid Mr P £100 for the trouble he went to in raising this issue. I think this is fair and reasonable in the circumstances.

What I've decided

Overall, I'm satisfied that HMCA provided sufficient information to Mr P and that it was clear, fair and not misleading. I understand that Mr P may now think that in retrospect the policy no longer meets his needs, but that doesn't mean that HMCA did anything wrong when the policy was taken out. I'm sorry to disappoint Mr P but it follows that I don't require HMCA to do anything further as I'm not persuaded that the policy was mis-sold.

My final decision

For the reasons given above, I don't uphold Mr P's complaint about HMCA Insurance Ltd.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or reject my decision before 8 July 2025.

Nimisha Radia
Ombudsman