

The complaint

Mrs S has complained that the price BUPA Insurance Limited charges her for a private medical insurance policy is significantly more than a new member would pay.

What happened

Mrs S's 2025 renewal quote was £7,065.73. She then discovered via a broker that a new member would pay only £3,848.40.

Our investigator thought that Bupa had acted reasonably in the way it had calculated the premium. Mrs S disagrees and so the complaint has been passed to me for 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.

It's important to make clear that we're not the industry regulator. We have no power to regulate the financial businesses we cover, or to direct them to change their processes or procedures. Insurers are entitled to decide what risks they are willing to cover, and what they charge for the cost of that cover, as long as they exercise their judgement fairly and consistently and in accordance with their internal guidelines. This service wouldn't normally get involved with how they calculate risk or their premium pricing structures.

What I can look at is whether Bupa has treated Mrs S fairly and reasonably. An important consideration of that is whether it has singled her out for additional costs or whether it has applied its increases consistently across other policyholders in a similar position. It wouldn't be fair if Bupa was looking at her policy in isolation and arbitrarily imposing higher premiums.

Mrs S has been with Bupa since 1979 and is concerned that historical claims, such as one from 35 years ago, are negatively impacting the cost of the policy.

Bupa didn't directly address this issue in its complaint response. However, it has now provided some information that will hopefully give some clarity on that point, although it is slightly technical in nature.

The policy she's on didn't have any claims related pricing mechanisms until 2011. At that stage it introduced a 'Low Claims Bonus' which took effect in 2012. That pricing mechanism looked at the value of claims paid in the previous year to calculate the size of the premium increase. That mechanism was in place until 2024, when the policy was transferred to Bupa Health. At that time, Mrs S benefitted from a reduced premium based on her claims' history. The 'Low Claims Bonus' was replaced by a 'No Claims Bonus', with the number of claims from the previous year influencing the renewal price.

I can see that the email accompanying the new quotes said: *'These are quotes for a new policy and will therefore not carry the burden of accumulated claims since the plan began.'* I'm not quite sure what the author meant by that, and Mrs S has understandably taken it to

mean that all previous claims from the start date have an impact on the price. However, based on the information provided by Bupa, I'm satisfied that old claims, such as the one from 35 years ago, are not impacting her current premium calculation. So, her original assumption that her coverage reflects past conditions but that the annual premium doesn't continue to reflect decades-old medical events, was essentially correct.

The difference in the prices she's seen are stark, so it's not surprising that she is challenging it. However, in looking at the cost of her policy against other quotes she has received, she is not comparing like for like.

Mrs S's policy has full medical underwriting. The quotes she has provided, one from Bupa and one from another provider, are both moratorium policies. I can't see the full details of these policies, but they exclude all medical conditions that someone has had during a period (typically five years, as for the Bupa quote) before the start date, until a trouble-free period (typically two years) after the start date. In contrast to that, as Mrs S has continuing cover, she is covered for all of her pre-existing medical conditions. That is therefore one of the reasons why the policy is more expensive – because it provides a more comprehensive level of cover.

To be clear, the price of a new moratorium policy isn't based on the medical conditions someone has had in the last five years and the risk that they might make a claim for those conditions. It is based on the fact that those medical conditions are completely excluded from cover, at least initially.

If Mrs S were to take out a new moratorium policy now, she'd be starting again and wouldn't have the benefit of continuing cover. So, any conditions that she'd had symptoms, treatment or investigations for in the last five years would be excluded from cover until an initial trouble-free period had passed.

I haven't seen details of her medical or claims history, but it's a matter for her whether she feels she can dispense with the benefit of continuing cover and instead take out a new moratorium policy.

Part of Mrs S's complaint is that Bupa hasn't provided her with enough information to make that decision. She says that its renewal notices say generic things about how customer may wish to shop around for a better price, which she doesn't feel is sufficient to alert her to the fact that she might be paying more as a long-standing member.

It is Mrs S's responsibility to ensure that the policy continues to meet her needs. The renewal notice doesn't make any claims about being the cheapest on the market, or even the cheapest for her in her particular circumstances. By saying that she might want to shop around, Bupa is explaining that she might be able to source an alternative policy at less cost. Overall, I consider that to be reasonable. I'm not persuaded that there have been any regulatory breaches in terms of the information provision.

Mrs S has talked about paying considerably more in relation to someone taking out a new moratorium policy. However, when looking at what is fair and reasonable, I'm considering whether Bupa is charging her more than someone else in a similar situation and who has the same type of policy.

As already mentioned, Bupa is entitled to make its own commercial decisions around risk and pricing, and this service wouldn't normally get involved with that. What I can look at is whether Mrs S has been treated the same as other long-standing members with similar circumstances. And, based on Bupa's underwriting evidence, I'm satisfied that she has.

I'm sympathetic to Mrs S's situation and understand she feels she is being penalised for her loyalty. However, I'm unable to conclude that Bupa has done anything significantly wrong in her case, as the pricing structure and increase in the 2025 premium has also been applied to other similar policyholders. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 13 April 2026.

Carole Clark
Ombudsman