DRN-4475074

The complaint

Mrs R complains that Vitality Health Limited won't pay her private medical insurance claim that it had authorised and about its service.

What happened

Mrs R had private medical insurance through her employer's group policy. The policy was insured by Vitality.

Mrs R made a pre-authorisation claim on the policy for private surgery. In August 2022 Vitality authorised the procedure. The surgery had been due to happen mid October 2022 but the hospital rescheduled the surgery to mid November 2022. On 25 October 2022 Mrs R called Vitality to tell it about the delay. On 28 October 2022 Vitality sent Mrs R a letter re-authorising the treatment and she had the surgery as planned.

In March 2023 Mrs R received a letter from the hospital saying Vitality hadn't paid her costs. She contacted Vitality to ask why and she says Vitality gave her confusing answers.

Vitality's final response letter to Mrs R said:

- It wouldn't pay her costs as the policy had been cancelled on 30 September 2022 due to her employer not paying the policy premiums and her treatment took place after the policy cancellation date.
- It had pursued her employer for the unpaid policy premiums but as it had only received premiums until September 2022 it had decided on 1 June 2023 to backdate the policy cancellation to 30 September 2022.
- Mrs R should raise her concerns with her employer's group secretary as it was the group secretary's responsibility to keep the employees informed about the policy.

Mrs R complained to us. In summary she said:

- She took Vitality's authorisation letter of 28 October 2022 in good faith and had the surgery only because Vitality had agreed to cover the procedure. Vitality was 'unethical and irresponsible' if it didn't pay the hospital as it had agreed. That would mean she would have to pay the costs and she didn't have the money to do so. The purpose of medical insurance is to protect her from those liabilities.
- Vitality delayed far too long in telling her about her employer's non-payment of the policy premium. She didn't know about problems with the policy until March 2023. If there were problems with her employer paying the premiums then Vitality should never have authorised her treatment.
- She had no control over the contract issues between her employer and Vitality and as the patient she shouldn't be punished. Vitality should pay her costs then pursue her employer for those costs.
- She'd received mixed messages in her calls with Vitality, it told her there were no problems with the policy then changed its mind.

- She wants Vitality to pay her full costs.

Our investigator said Vitality had acted reasonably in not paying Mrs R's costs. But he recommended Vitality pay Mrs R £150 compensation for her distress and inconvenience and loss of expectation due to it giving her wrong information about the policy in May 2023.

Mrs R disagrees and wants an ombudman's decision. She emphasised that Vitality had authorised her treatment when the policy was still in place and knowing it was having difficulty receiving premiums from her employer. It knew it could cancel the policy if her employer didn't pay. Mrs R also set out how she understood a home insurance claim would work if an insurer approved a home repair but a consumer changed to another insurer before the repair work was done.

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've considered all the points Mrs R has made but I won't address all her points in my findings. I'll focus on the reasons why I've made my decision and the key points which I think are relevant to the outcome of this complaint.

The relevant regulator's rules say that insurers must handle claims promptly and fairly and they mustn't turn down claims unreasonably.

I'm sorry to disappoint Mrs R, I feel a lot sympathy for her as she's in a situation where she owes the hospital a considerable amount of costs through no fault of her own. But I think Vitality has reasonably declined to pay the costs it authorised. I'll explain why.

The policy says under the section headed 'Conditions of your Plan'.

> *'Your entitlement to benefit will end after the last day of your cover. We will only be liable for the cost of eligible treatment that takes place before that date. Once your cover under this plan ends, no further benefit will be payable for any treatment received after that date by you or any of your insured dependants.*
>
> *This will be the case even if;*
>
> ** a claim started before your cover ended, or*
> ** you or any of your insured dependants are in the middle of treatment, or*
> ** we have authorised treatment that is due to take place after your cover has ended…'*

So the policy is clear that Vitality won't pay any costs that are incurred after the policy ends even if it has authorised treatment that is due to take place after the policy ended. Vitality acted in line with the policy terms when it told Mrs R it wouldn't pay the costs it had re-authorised in August 2022 as her treatment happened in November 2022 which was after the last day of policy cover on 30 September 2022.

I've also considered what's fair and reasonable given all the circumstances.

Mrs R has detailed how she thinks home insurance would work in a comparable situation. But even if I thought that was correct, this is a private health insurance policy and the above policy terms are not unusual for private health insurance policies.

I think Vitality was acting reasonably when it sent the authorisation letter to Mrs R on 28 October 2022. At that date Mrs R's employer had paid the outstanding August and September 2022 premiums, Vitality had spoken to her employer and the direct debit for the premiums had been reactivated. I think Vitality reasonably understood that her employer would pay the further premiums. Vitality's notes show that it was on 23 November 2022 that the direct debit collection for the October and November 2022 premium was rejected, which was after Mrs R had surgery.

Even if I thought Vitality should have reasonably had concerns about Mrs R's employer not paying further premiums (which I don't think for the reasons given above) Vitality wasn't in a position to tell Mrs R. The 'Group Secretary Plan Terms and Conditions' between Vitality and her employer are clear that it's for the employer's group secretary to tell employees about changes to the plan. And the policy document sent to Mrs R says Vitality will discuss policy administration issues only with the group secretary, acting on behalf of the plan holder, and not with any individual insured member.

I also think Vitality acted reasonably in saying the policy ended on 30 September 2022. Vitality didn't make that decision until 1 June 2023 but that's because during the interim period it was chasing Mrs R's employer for the outstanding premiums, unsuccessfully. The employer had paid the policy premium for September 2022 and the 'Group Secretaty Plan Terms and Conditions' say:

> *'Your entitlement to benefit will end after the last day of the period covered by the final premium payment. In such circumstances, we will only be liable for the cost of eligible treatment that takes place before that date'.*

So under the policy terms Vitality could reasonably backdate the policy end date to 30 September 2022 which was the last day of the period covered by the final premium payment.

I agree with Mrs R that she had no control over whether her employer paid the policy premiums. I understand why she thinks she's been left in the very unfair position of having to pay her treatment costs. But for the reasons above I'm satisfied that Vitality did nothing wrong in authorising her treatment when it did, subsequently ending the policy on 30 September 2022 and in not paying for the costs it had authorised. So I can't fairly say Vitality should pay Mrs R's cost then pursue her employer for the costs.

I understand Vitality suggested to Mrs R that she speak to her employer as it's due to them not paying the premiums which has left her with no policy cover after 30 September 2022, and I think that's a reasonable suggestion.

Vitality did give Mrs R conflicting information about the situation. In March 2023 Vitality correctly told her there was a problem with payment on the policy and until there was an active payment on the account no claims could be approved. In early May 2023 Vitality told Mrs R the policy was up to date, there was no need to worry about her outstanding invoices which would be sent to its billing department, which was wrong information. When later in May 2023 Vitality correctly told Mrs R there was still a problem with the policy, Mrs R was caused confusion, distress and a loss of expectation. I think the £150 compensation our investigator recommended Vitality pay Mrs R for those issues is a fair amount.

I should emphasise that the £150 compensation only relates to Mrs R's distress and inconvenience and loss of expectation Vitality unreasonably caused by giving her wrong information. Mrs R is understandably very upset and stressed about being left to pay her treatment costs, she's told us she'll suffer a lot of financial hardship. But as I think Vitality

reasonably isn't paying those costs I've no basis for increasing the compensation for Mrs R's distress and inconvenience that Vitality isn't responsible for.

Putting things right

Vitality must pay Mrs R £150 for her distress and inconvenience and loss of expectation it unreasonably caused due to giving her incorrect information.

My final decision

I partly uphold this complaint and require Vitality Health Limited to pay Mrs R £150 for her distress and inconvenience and loss of expectation it unreasonably caused due to giving her incorrect information.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs R to accept or reject my decision before 10 January 2024.

Nicola Sisk
Ombudsman