DRN-4277686

The complaint

Mr L complains about the way that BUPA Insurance Limited has handled a claim he made on a personal private medical insurance policy.

What happened

Mr L had private medical insurance with BUPA under his employer's group scheme. Once Mr L left that employment, he took out personal continuation cover with BUPA.

In September 2022, Mr L contacted BUPA to make a claim on the policy. He wanted to obtain pre-authorisation for a cardiology referral, after he'd spoken to a private GP about symptoms he'd been experiencing. The private GP had told Mr L he had angina. BUPA wrongly told Mr L on 26 September 2022 that as his symptoms pre-dated the start of his personal policy, his claim wouldn't be covered. Mr L made a complaint about BUPA's decision to turn down his claim.

Mr L saw an NHS GP, who told him to continue taking medication. The GP also told him that if he continued to experience persistent chest pain, he should go to A&E.

On 18 October 2022, Mr L's chest pain worsened and he was taken to A&E. Unfortunately, Mr L had suffered a non-ST-elevation myocardial infarction (NSTEMI) and he was admitted to an NHS hospital. Around 10 days later, he was transferred to another NHS hospital, where he eventually underwent quadruple bypass surgery. In total, he was in hospital for 27 days.

In the meantime, on the 19 October 2022, the day after Mr L had been admitted to hospital, BUPA tried to get in touch with him by phone. It had reviewed Mr L's claim and it concluded that as Mr L's policy was a continuation contract, his request for a cardiology referral ought to have been authorised. So BUPA tried to call Mr L to provide him with an update. As, understandably, Mr L didn't answer the call, BUPA wrote to him to let him know that it would authorise a cardiology appointment. And it said it would pay him £100 compensation.

Once Mr L had been discharged from hospital, he got in touch with BUPA again to follow-up on his complaint. He felt that had BUPA authorised a cardiology referral at the outset, he would've been able to undergo treatment privately. Instead, he felt its actions had led to the NHS unnecessarily bearing the costs of his treatment. He therefore thought that BUPA should pay the NHS hospital the costs of the treatment he'd received. And he considered BUPA should compensate him for the anxiety and upset he'd suffered.

BUPA told Mr L that it wasn't able to pay the hospital the costs of his NHS treatment. But it said that it had given feedback to its staff around handling claims on continuation policies. It let Mr L know that he could make an NHS cash benefit claim on the policy if he wished to do so. It didn't agree that it was likely that Mr L would have been able to undergo bypass treatment privately had it pre-authorised his initial referral claim. But it did say it would pay Mr L a further £500 compensation for the trouble and upset he'd experienced.

Mr L remained unhappy with BUPA's position and he asked us to look into his complaint. He

referred to the significant premiums he'd paid over the years for the cover and he felt that he should get these back.

Our investigator didn't think BUPA needed to do anything more. She accepted that BUPA had wrongly turned down Mr L's initial claim. But she felt that BUPA had taken fair and reasonable steps to put things right. And she concluded that a total of £600 compensation was a fair award to reflect the error BUPA had made.

The investigator didn't think that we could ask BUPA to reimburse the NHS for the costs of Mr L's treatment – as Mr L hadn't incurred a direct loss for these costs and because the NHS wasn't a policy beneficiary. And she didn't think it was likely that Mr L could have arranged a cardiology appointment and undergone the necessary testing before his cardiac condition worsened. Additionally, she felt that Mr L had had the benefit of private medical cover over many years and that it wouldn't be fair or reasonable to ask BUPA to refund the premiums he'd paid.

Mr L disagreed and I've summarised his responses to the investigator. He questioned what BUPA would have done had it managed to speak with him on 19 October 2022, when he was already in hospital. He said he'd attended A&E because this had been the only option to him given the decline of his claim – he'd followed his GP's advice. He felt the investigator had disregarded his comments relating to what he considered to be fair compensation. BUPA had relied on a policy exclusion for admission via A&E to refuse to pay his treatment costs. He felt that any reimbursement of his treatment costs from BUPA to the NHS was a more complex situation than this service is used to resolving. He also queried how many other customers had had treatment on the NHS which should have been covered privately by BUPA. He told us he'd spoken to members of government and other officials about this matter. BUPA has now applied an exclusion to the terms of Mr L's policy for claims related to chest pain.

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 Mr L, I think BUPA has already settled this complaint fairly and I'll explain why.

I'd like to reassure both parties that while I've summarised the background to this complaint and the parties' submissions, I've carefully considered all that's been said and sent to us. Within 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 think are the key issues.

It's important I make the parameters of this decision clear. First, Mr L has referred to the fact that BUPA appears to have applied an exclusion to his policy for chest pain. He told us he wanted us to look into this issue. It isn't clear that Mr L has complained to BUPA directly about this issue though and therefore, as the investigator explained, we cannot look into it as a part of this complaint. That's because the regulator's rules say that a financial business must be given eight weeks to investigate a complaint and issue a final response, before we can potentially look into that issue.

Secondly, this complaint concerns BUPA's handling of *Mr L's* claim – as he was one of those insured under the terms of his particular contract. Accordingly, this decision will only consider whether BUPA handled Mr L's claim fairly, taking into account the individual circumstances of his complaint. I won't be looking at any concerns Mr L may have about the way BUPA has handled other policyholders' claims or administered their policies.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. In this case, BUPA acknowledges that it shouldn't have turned down Mr L's claim in September 2022. And its final response letters indicate that it paid him compensation of £600, together with offering him an apology and providing feedback to its staff. So I've gone on to consider whether I think this was a fair and reasonable way to put things right.

At the outset, Mr L sought pre-authorisation for a referral to cardiology for angina. After the claim was wrongly turned down on 26 September 2022, Mr L went on to see his NHS GP. By Mr L's account, the NHS GP didn't refer Mr L to cardiology. They suggested that Mr L carry on taking medication and that he should go to A&E if his chest pain worsened.

Mr L says that he suffered an NSTEMI sometime between 15 and 18 October 2022. He accordingly visited A&E, in line with his GP's advice and was admitted for treatment on 18 October 2022. So it appears he suffered an NSTEMI around three weeks after his claim had been erroneously turned down. Mr L thinks that had BUPA authorised a referral to cardiology, the cause of his chest pain would have been discovered and treatment would have taken place privately.

I've thought about this very carefully. But on balance, even if BUPA *had* authorised the claim in September 2022, I don't think it's likely that Mr L could have arranged an appointment with a cardiologist; undergone any necessary testing; received a diagnosis; and have arranged and undergone surgery within a three week period. I've seen no persuasive medical evidence which shows that Mr L would have been able to undergo private surgery more quickly than he did. On balance, I find it's more likely than not that even if BUPA had authorised the referral, Mr L would still have needed to visit A&E when his chest pain worsened. And I think it's more likely than not that he would still have needed to be admitted via A&E for treatment in an NHS hospital.

As such, while I can't say with certainty what would have happened had BUPA been able to speak with Mr L on 19 October 2022, I think it's likely that his emergency treatment would still have been provided by the NHS and he would have remained under the care of the NHS while he underwent surgery. It's simply the case that sometimes, the NHS is best placed to provide medical treatment – particularly in emergency situations. And given the exclusion for treatment following an A&E admission, I don't think it's likely BUPA would've gone on to cover Mr L's emergency treatment in any event.

It's clear how strongly Mr L believes that BUPA should reimburse the NHS for the costs of his treatment. I'm afraid I don't agree. An insurance contract is generally a contract of indemnity – it covers policyholders for their own insured losses. Mr L didn't incur any direct costs for his NHS treatment – these were met by the NHS. Mr L was the policy beneficiary and he was the 'risk' BUPA was insuring. As he didn't incur any direct financial costs, BUPA isn't required to pay any private medical bills under the terms of the insurance contract. So I'm not directing BUPA to make any payment to the NHS hospitals which treated Mr L. I'd add too that we're competent to resolve - and experienced in resolving - complex disputes and I'm satisfied that we're able to make a fair and reasonable finding on this particular complaint point (and indeed, that we have done so here).

I can understand why Mr L wants a refund of the policy premiums he's paid. However, I don't think it would be fair for me to make such an award. Mr L has had the benefit of the cover BUPA was providing over the years, even if he hasn't previously needed to make claims. I don't think it would be reasonable or appropriate for me to award a refund of premiums simply because BUPA made a mistake when it assessed Mr L's claim. It remains open too to Mr L to make an NHS cash benefit claim for the period he was an in-patient in hospital. Should he now wish to do so, he should send BUPA the evidence it's requested, so that it

can consider an NHS cash benefit claim.

BUPA did make a clear error when it wrongly turned down Mr L's claim. This undoubtedly did cause Mr L some trouble and upset and I don't doubt how frustrating the situation has been for him, particularly when he experienced serious illness. It's fair that BUPA should pay compensation for its error. It has provided feedback to its staff, which I'd expect it to do, and it's apologised to Mr L. Again, this is in line with what I'd expect it to do. In total, BUPA's letters indicate it has paid Mr L £600 compensation to reflect his distress and inconvenience. I appreciate Mr L believes BUPA should pay him substantially more. But I find the compensation it appears BUPA has already paid Mr L is fair to reflect the nature of its mistake and the likely impact I think it had on him. So while I know my decision will come as a disappointment to Mr L, I'm not telling BUPA to do anything more. If Mr L didn't receive the compensation payments by BACS, he should let BUPA know.

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 Mr L to accept or reject my decision before 11 September 2023.

Lisa Barham
Ombudsman