DRN-4656650

The complaint

Ms P complains that AXA PPP Healthcare Limited hasn't settled a claim she made on a personal private medical insurance policy.

What happened

Ms P took out a personal private medical insurance policy in November 2019 on moratorium underwriting terms. At renewal in November 2022, Ms P asked to add mental health cover to her policy. AXA agreed to add this option to Ms P's policy in December 2022.

In early January 2023, Ms P contacted AXA to make a claim on her policy for anxiety. Following a triage appointment, AXA authorised for Ms P to see a psychiatrist. She underwent an assessment with a psychiatrist in February 2023 and a follow-up in April 2023. The psychiatrist recommended that Ms P should undergo six to twelve sessions of cognitive behavioural therapy (CBT). AXA provided an authorisation code for this treatment.

Subsequently, in May 2023, AXA decided that it needed further information before it could accept Ms P's claim. That's because it noted that the psychiatrist's letter had referred to Ms P previously suffering from PTSD. So it wanted to assess whether Ms P's claim was excluded by the terms of the moratorium. In the meantime, Ms P had undergone two sessions of CBT and incurred treatment costs.

Ms P was unhappy with AXA's position and she complained. She provided a letter from a psychiatrist which stated that Ms P hadn't been treated for PTSD. But AXA maintained its stance and reiterated that it needed more evidence before it could accept Ms P's claim. So Ms P asked us to look into her complaint.

Our investigator didn't think AXA had treated Ms P unfairly. She felt the available medical evidence indicated that Ms P may have suffered from symptoms of a mental health condition in the five years before the policy was taken out. Therefore, she thought it was reasonable for AXA to require further medical evidence to assess whether or not Ms P's claim was excluded from cover.

I issued a provisional decision on 16 February 2024 which explained why I thought Ms P's complaint should be partly upheld. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Ms P's policy and the available evidence, to decide whether I think AXA treated her fairly.

I've first considered the terms and conditions of the policy, as these form the basis of the contract between AXA and Ms P. It's common ground that Ms P took out the policy on moratorium terms. The policy says:

'If you joined us on moratorium terms, it means that you won't have cover for treatment of medical problems you had in the five years before you joined us 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 joined, that have been trouble-free from that condition.'

'Trouble-free is defined as follows:

'Trouble-free means that you have not done any of the following for the medical condition you need treatment for:

• had a medical opinion from a medical practitioner, including a GP or specialist
• taken medication (including over-the-counter drugs)
• followed a special diet
• had medical treatment
• visited a practitioner, therapist, homeopath, acupuncturist, psychologist, cognitive behavioural therapist, optician or dentist.'

I think the policy terms make it clear that under the terms of the moratorium, AXA won't pay claims for conditions a policyholder had in the five-years before the policy began, unless they've been a member for more than two years and have been trouble-free from a condition.

In this case, Ms P's claim centres on CBT to treat anxiety. Her psychiatrist provided a report dated 16 February 2023. This includes the following:

'(Ms P) explained to me that she has been experiencing increased anxiety which is present all the time and she can very rarely feel relaxed. She has in the past, experienced panic attacks and her current experience of a very busy and wired brain is that she can experience symptoms of a panic attack starting. She wants her anxiety to improve significantly.'

I think this letter is suggestive that Ms P might have had symptoms of anxiety previously and which may have existed before she added the mental health cover to her policy in late 2022. I note too that in a letter dated 8 August 2023, another psychiatrist stated:

'I am reviewing Ms P as an outpatient and have been doing so for several years.

She presented with anxiety and insomnia.'

Again, this letter appears to indicate that Ms P had been under the care of a psychiatrist for several years and that she'd presented with anxiety and insomnia. So I think it was reasonable for AXA to want to be satisfied both that the claim wasn't excluded by the moratorium clause and that Ms P hadn't been undergoing or waiting for treatment at the point she added mental health cover to her policy.

The policy terms entitle AXA to request further medical evidence from a treating doctor before it agrees to accept and pay a claim. Based on the available evidence, I don't think it was unreasonable for AXA to require further information from Ms P's treating specialists about the nature and duration of her symptoms before it confirms further cover. It's open to Ms P to provide AXA with the information it's requested should she wish it to consider the costs of any further sessions of CBT.

However, on the facts of this case, I do think AXA should accept and assess cover for any invoices for the CBT sessions Ms P actually attended prior to 21 June 2023, as I'll explain.

AXA's notes show that it received the psychiatrist's report of February 2023 in March 2023. As I've set out above, I think this letter was suggestive that Ms P might already have had

symptoms of anxiety and that there might be an issue with cover. And AXA has referred to its concerns that Ms P may already have known she needed treatment at the point she called to add on the mental health option, given comments it says she made on the call.

However, at the point Ms P requested authorisation for CBT in April 2023, AXA didn't request further information to validate the claim. It was open to AXA, as the expert in this situation, to recognise that Ms P's condition might not be covered and to ask for more medical evidence. But it didn't do so. Instead, it simply provided an authorisation code for Ms P to undergo treatment. I don't think it was unreasonable for Ms P to act on this authorisation and receive CBT when it doesn't seem she had any reason to think the claim might not be eligible.

It doesn't appear that AXA made a formal note that there could be an issue with cover until 15 May 2023, three days before Ms P's initial CBT appointment. It was open to AXA to request more information from Ms P at this point too and allow her to cancel the appointment. I think this would have been a reasonable and fair course of action. But it didn't do so. It didn't let Ms P know there was an issue with the eligibility of her claim until 21 June 2023, over a month later and after Ms P had already incurred the costs of treatment.

Ms P seems to have stopped undergoing CBT treatment when she learned there was a problem with cover. So it seems to me that if she'd known AXA needed more evidence to validate her claim ahead of the appointment on 18 May 2023, she'd most likely have cancelled that appointment too. As such, on balance, I don't think she'd have attended the appointments on 18 May and 15 June 2023 and therefore, I don't think she'd have incurred the costs of CBT treatment.

On that basis, I currently think that while AXA's reasonably entitled to require further medical evidence to validate Ms P's claim after 21 June 2023, it should accept and assess Ms P's invoices for 18 May and 15 June 2023, in line with the remaining terms and conditions of the policy. Ms P incurred a cancellation fee on 8 June 2023 due to non-attendance at a CBT appointment and so I don't think it would be fair or reasonable for me to direct that AXA should also consider this charge.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Ms P questioned why the evidence she'd already provided wasn't sufficient. She said that if AXA was insistent on being sent a copy of the GP form, she'd grudgingly provide it. However, she felt AXA was constantly moving the goal posts. And she queried whether AXA would be able to continue to force her to pay out to get more information until it had exhausted all ways to get out of paying her claim.

AXA didn't accept my provisional decision. It said it appreciated that it could have dug a bit deeper at the start. But it said it relied on its members giving a true and accurate account of their medical history and it didn't think I'd taken this into account. It said Ms P had told it she'd had anxiety symptoms for a month and had then refused to provide medical evidence to show the history of her symptoms. It felt that paying for the CBT treatment up until 21 June 2023 rewarded Ms P's lack of transparency.

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, my final decision is the same as my provisional decision and for the same

reasons. I appreciate AXA didn't agree with my provisional findings and so I'll explore its response further.

As I explained in my provisional decision, I appreciate that AXA had concerns that Ms P may already have been experiencing symptoms of anxiety at the time she asked to add the mental health cover to her policy. I'm mindful that AXA says that at the point Ms P requested the add-on cover, it asked her questions about whether she'd suffered from mental health conditions (including anxiety) in the previous five years. And I accept that the medical evidence which is currently available to AXA suggests that Ms P's anxiety claim may well fall within the moratorium exclusion. So I can understand why AXA has some concerns that Ms P may have been experiencing symptoms of anxiety when she purchased the add-on cover. I've considered these points carefully when reaching what I consider to be a fair and reasonable outcome in the particular circumstances of this complaint.

And my provisional decision made it clear that given the available medical evidence, I don't think it's unreasonable for AXA to require further medical information from Ms P's treating doctors about the duration and nature of her symptoms before it confirms any further cover.

However, it remains the case that on 15 March 2023, AXA received a psychiatrist's report dated 16 February 2023. This letter made reference to Ms P suffering from increased anxiety and having previously experienced panic attacks. I think this ought to have put AXA on reasonable notice that it might need further information to validate the claim. But it didn't take any action. Instead, it authorised a claim for CBT in April 2023. And even when it *did* notice a potential issue with the eligibility of the claim on 15 May 2023, AXA didn't contact Ms P until 21 June 2023 to let her know there was a potential issue. By that point, as I've explained, Ms P had already undergone two sessions of CBT – including one session on 18 May 2023.

In my view, AXA was acting as the expert in this situation. I think it had enough evidence to suggest there might be an issue with cover as early as March 2023. And I think, at the latest, it ought reasonably to have brought its concerns to Ms P's attention and asked her for more medical evidence following its claim review on 15 May 2023. Had it done so, it still seems most likely to me that she'd have chosen to cancel any existing appointments without charge rather than undergo treatment which might not be covered. I say that because the evidence shows Ms P decided to stop treatment once she knew her claim hadn't been validated. I've seen no evidence that Ms P would have been unable to cancel her appointment on 18 May 2023 without penalty. Neither do I think she'd have arranged nor attended CBT treatment on 15 June 2023 had she been aware of AXA's concerns about the validity of her claim.

So it's still the case that I don't think Ms P would have incurred the costs of two CBT appointments if AXA had made her aware of its concerns far sooner than it did. This means I think AXA prejudiced Ms P's financial position. And therefore, I'm still satisfied that on the specific facts of this complaint, the fair and reasonable outcome is for AXA to accept and assess Ms P's invoices for her CBT appointments on 18 May and 15 June 2023, in line with the remaining terms and conditions of the policy.

I must make it clear that I remain persuaded that AXA is reasonably entitled to require further medical evidence to validate Ms P's claim after 21 June 2023. It will be for AXA to determine what evidence it considers to be necessary to show the duration and nature of Ms P's symptoms. It wouldn't be appropriate for me to set out *exactly* what evidence it should ask for. However, if Ms P is unhappy with AXA's assessment of any *new* medical evidence she may choose to provide it with, she may be able to make a new complaint to it about that issue alone.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I think AXA is reasonably entitled to require further medical evidence to allow it to assess Ms P's claim after 21 June 2023.

But I direct AXA PPP Healthcare Limited to accept and assess Ms P's invoices for 18 May and 15 June 2023, in line with the remaining terms and conditions of the policy.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms P to accept or reject my decision before 3 April 2024.

Lisa Barham
Ombudsman