DRN-5051988

The complaint

Mr and Mrs T complain that BUPA Insurance Limited has turned down a claim they made on a personal private medical insurance policy.

Mr and Mrs T have a representative acting on their behalf, but for ease of reading, I've referred mainly to Mr T.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mr and Mrs T have held a personal private medical insurance policy for many years. In 2016, 2017 and 2018, BUPA paid for Mr T to undergo injections to treat pain in his lumbar spine.

Unfortunately, Mr T began to suffer further back pain and he was diagnosed with spondylolisthesis which had resulted in lumbar spine nerve compression. He was therefore booked in to undergo a further spinal injection in early January 2024. So he made a claim on the policy.

BUPA turned down Mr T's claim. Its medical advisers concluded that as Mr T had already had three injections in the same area of his spine, any further injections would be unlikely to resolve his condition permanently. So BUPA considered that Mr T's condition was chronic and therefore excluded by the policy terms.

Mr T was very unhappy with BUPA's decision and he asked us to look into his complaint. In brief, he and his treating doctor, who I'll call Mr K, both considered that Mr T's diagnosis was a new, acute condition, with new, acute symptoms. They felt that the policy covered acute, unexpected symptoms which resulted from a flare-up of a chronic condition. So they considered that BUPA should pay for Mr T's treatment. Both Mr T and Mr K raised concerns about the way the policy was drafted, particularly in relation to chronic conditions, and they felt that BUPA needed to provide far more detail as to what was and wasn't covered.

Our investigator didn't think Mr T's complaint should be upheld. She took into account BUPA's internal guidance which supported its claims decision. And she felt BUPA had fairly relied on that guidance to turn down Mr T's claim. While she accepted that Mr T did have a new diagnosis with new, acute symptoms, she noted that BUPA only covered a flare-up of acute symptoms of a chronic condition if the treatment would be curative or would restore a policyholder fully to their previous state of health. She didn't think there was medical evidence which showed this was the case. And she didn't think it would be fair or reasonable to require BUPA to detail internal guidance in its policy terms.

Mr T disagreed and Mr K also provided some further comments. I've summarised their detailed further submissions below:

- How the policy had been sold was a fundamental part of this complaint and should be considered;

- The sale of private medical insurance is regulated and it's unreasonable for an insurer to conceal information which might affect a policyholder's decision whether or not to take out a policy;
- In particular, they considered private medical insurers concealed information about the chronic condition exclusion and they felt insurers changed the criteria secretly; making it impossible for a policyholder to make an informed decision about private medical insurance and potentially wasting significant amounts of money on cover for policies which won't pay out. Mr T said he'd based his cover decision on the policy documents, which didn't set out BUPA's underwriting criteria;
- They had concerns that BUPA changed its cover criteria without telling customers
- It's unreasonable for an insurer to hide its internal criteria from policyholders and they wished for a deep analysis of these issues;
- Mr T had a new, acute condition which Mr K considered should be covered.

The complaint's been passed to me to decide.

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 and Mrs T, I don't think it was unfair for BUPA to turn down Mr T's claim and I'll explain why.

First, I'd like to reassure Mr T that while I've summarised the background to this complaint and the detailed submissions which have been sent to us, I've carefully considered all of the evidence which has been provided. In 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 consider to be the key issues.

It's also important I make clear our role. We're not the industry regulator. We don't generally tell financial businesses how to operate or tell insurers what risks they should and shouldn't cover. Our role is to consider complaints brought by individual consumers. We'll decide, based on all the evidence and the circumstances of each specific complaint, whether we think a financial business has done something wrong which has caused a consumer to lose out. And, if we think it has, we'll consider what, if anything, the financial business needs to do to put things right. Necessarily then, my decision will focus on whether I think BUPA has handled Mr T's claim fairly, in the individual and specific circumstances of his complaint. I won't be commenting on any wider concerns Mr and Mrs T or Mr K may have about other insurers or the wider private medical insurance industry.

It's also clear Mr and Mrs T have raised concerns about the way the policy was sold. But this wasn't the complaint they made to BUPA and therefore, BUPA hasn't had an opportunity to specifically address a complaint about the policy sale. Under our rules, a financial business must be given a chance to look into a consumer's complaint and provide a final response before we can potentially help with it. Therefore, it wouldn't be appropriate for me to comment specifically on any concerns Mr and Mrs T have about the way this policy was sold or whether BUPA met its regulatory obligations at the time of sale.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations, such as industry principles, the policy terms and conditions and the medical evidence, to decide whether I think BUPA handled Mr T's claim fairly.

I've first considered the policy terms and conditions, as these form the basis of Mr and Mrs T's contract with BUPA. The policy provides cover for eligible treatment. BUPA has explained what it considers to be eligible treatment. But the contract also sets out a specific list of risks BUPA has chosen not to cover. This includes the following term:

'We do not pay for treatment of chronic conditions. By this, we mean a disease, illness or injury which has at least one of the following characteristics:

- *it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests*
- *it needs ongoing or long-term control or relief of symptoms*
- *it requires your rehabilitation or for you to be specially trained to cope with it*
- *it continues indefinitely*
- *it has no known cure*
- *it comes back or is likely to come back.*

Exception: ***We pay for eligible treatment arising out of a chronic condition, or for treatment of unexpected acute symptoms of a chronic condition that flare up. However, we only pay if the treatment is likely to lead quickly to a complete recovery or to you being restored fully to your previous state of health, without you having to receive prolonged treatment.*** *For example, we pay for treatment following a heart attack arising out of chronic heart disease. We do not pay for treatment required due to the expected deterioration or flare up of a chronic condition. This includes conditions which have a relapsing-remitting nature and require management of recurrent flare-ups, for example, inflammatory bowel disease. In such cases, the flare-ups are an expected part of the normal course of the illness and therefore we do not consider them as acute complications of the disease.'* (My emphasis added).

In my view, BUPA's policy terms make it sufficiently clear that chronic conditions aren't covered and what BUPA considers a chronic condition to be. And in my experience, most, if not all, private medical insurers define chronic conditions in a very similar way. I don't find BUPA's policy documents to be unclear or misleading.

BUPA concluded that Mr T's spinal condition was chronic, given it had already paid for three spinal injections for him in the same region of his back in 2016, 2017 and 2018. Therefore, its medical advisers concluded that Mr T's symptoms would come back or were likely to come back. BUPA also provided us with a copy of its commercially sensitive, confidential underwriting criteria which, in brief, sets out this position.

I appreciate that Mr T's diagnosis of spondylolisthesis is a new diagnosis. Mr K has told us that Mr T's new diagnosis is a new, acute condition, with new acute symptoms. I've carefully considered this point. However, as I've explained, the exception to the chronic condition exclusion *only* applies if the treatment of a flare-up of a condition will lead to a complete recovery or restore a policyholder fully to their previous state of health. I haven't seen any persuasive medical evidence which indicates that a further spinal injection will either cure Mr T's spondylolisthesis or that it will fully restore him to his previous state of health.

As such then, I don't think it was unfair or unreasonable for BUPA to rely on the opinion of its medical advisers and on its underwriting guidance to conclude that Mr T's claim was for the treatment of a chronic condition. And nor do I think there's enough medical evidence to show that Mr T's claim meets the terms of the policy exception. Therefore, I don't think BUPA acted unfairly when it turned down Mr T's claim.

It's clear how strongly Mr T believes that BUPA should set out its underwriting guidance in its policy terms. However, I don't think it would be fair or reasonable for me to direct BUPA to

set out each and every form of treatment or condition it does or doesn't cover in the policy terms. As I've set out above, I'm satisfied that the policy terms make it clear that BUPA doesn't cover chronic conditions and how it defines chronic conditions. And I'm satisfied that BUPA has demonstrated that it's handled Mr T's claim in line with the policy terms and in line with its underwriting criteria. So I find that BUPA has treated Mr T in the same way it would treat any of its other customers in a similar situation to Mr T and that it hasn't singled him out in any way.

Overall, whilst I sympathise with Mr T's position, I don't think there are any reasonable grounds upon which I could direct BUPA to pay his claim. So it follows I'm not telling it to do anything more.

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 Mrs T and Mr T to accept or reject my decision before 18 December 2024.

Lisa Barham
Ombudsman