DRN-5093905

The complaint

Mr and Mrs B complain that Western Provident Association Limited (WPA) hasn't agreed to fully cover a claim they made on a personal private medical insurance policy.

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 B took out a personal private medical insurance policy in February 2020. The policy states that WPA will pay what it considers to be reasonable and customary costs for eligible treatment.

Later that year, Mr B made a claim on the policy as he was suffering from osteoarthritis in both hips. WPA covered various investigations and treatments for this condition.

Subsequently, in early 2024, Mr B's consultant (who I'll call Mr K) confirmed that Mr B would need a double hip replacement operation. WPA's fee memorandum stated that it would pay £1800 for surgery of this type – what it considered to be a reasonable and customary fee. However, Mr K's charges totalled £4000 more than WPA's stated fee. This meant Mr and Mrs B would be responsible for paying the £4000 shortfall.

Mr and Mrs B went ahead and booked the surgery. But they complained to WPA because they didn't think it was fair for its payment for the operation to be limited to £1800. In brief, they didn't feel that WPA took into account a specialist's expertise and knowledge. And they questioned why they hadn't been informed about potential shortfalls they'd be responsible for paying at the outset.

WPA maintained its stance and so Mr and Mrs B asked us to look into their complaint.

Our investigator didn't think Mr and Mrs B's complaint should be upheld. She felt the policy terms made it clear that if treatment fees exceeded what WPA considered to be customary and reasonable costs, a policyholder would be responsible for paying any shortfall. She explained that we wouldn't tell an insurer what fees it should pay consultants or how it should set its rates. And she noted that Mr and Mrs B hadn't called WPA for authorisation ahead of arranging the surgery, so she didn't think it had been in a position to specifically highlight the shortfall which would apply.

Mr and Mrs B disagreed and I've summarised their detailed responses to our investigator:

- Regulatory rules required financial businesses to provide information about a policy in good time and in a comprehensible form to allow a customer to make an informed decision about the proposed arrangements. The rules also required insurers to provide information which was clear, fair and not misleading;
- Mr and Mrs B considered WPA hadn't met its regulatory obligations. They said WPA hadn't provided them with a list of all the specialists who charged a fee 'uplift' and they felt this was basic information a potential customer should be entitled to in order

to make a decision about purchasing the insurance. In brief, they believed the policy had been mis-sold to them;
- They believed that while the policy stated a policyholder had freedom to choose their own specialist, this was misleading. That's because they felt the policy failed to make it clear that a policyholder could only choose specialists who charged within WPA's fee structure and that they could otherwise be liable for thousands of pounds;
- Mr K had provided Mr B with treatment on eight occasions since 2020 and at no point during that time had WPA let Mr and Mrs B know that Mr K charged a fee uplift. They felt WPA had known that Mr B would need hip replacement surgery and it had been reasonable for them to assume that that surgery would be covered in full. They felt WPA ought to have highlighted the possibility that Mr K might charge an uplift at the outset;
- WPA had failed to provide Mr and Mrs B with the details of an equally renowned and experienced surgeon whose fees would not exceed its stated limits;
- They considered it had been misleading for WPA to state that only 'very occasionally' would shortfalls be payable, when in 2022/23, 29% of hip replacements had been charged above WPA's stated fee;
- They didn't feel it was reasonable for them to be responsible for paying more towards the costs of the surgery than WPA;
- They considered WPA lacked transparency as to the members of its Medical Advisory and Clinical Governance Committee and as to how the Committee decide what are reasonable and customary charges for consultants.

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 B, I don't think WPA has treated them unfairly and I'll explain why.

First, I'd like to reassure Mr and Mrs B that while I've summarised the background to this complaint and their detailed submissions to us, I've carefully considered all that they've said and sent. 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 and remit. We're not the industry regulator. We can't tell financial businesses how to operate or to tell them to change their processes and procedures. Nor will we tell insurers what risks they should and shouldn't cover. And the fee arrangements an insurer enters into with a third-party clinician or a provider are matters of that insurer's commercial judgement. So I won't be telling WPA what fees it should charge or what factors it must take into account when it determines what it considers to be customary and reasonable treatment fees. And neither can I tell WPA to publish lists of all consultants who charge more than its agreed fee schedule.

In my view, the key points are for me to decide whether it was fair for WPA to decline to pay the full cost of Mr B's proposed surgery and whether WPA has provided them with clear, fair and not misleading information about the policy cover. I'll deal with each point in turn.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that insurers must provide policyholders with clear, fair and not misleading information about their cover. I've taken those rules into account, amongst other relevant considerations, such

as the regulator's principles, the policy terms and the available evidence, to decide whether I think WPA has treated Mr and Mrs B fairly.

Was it fair for WPA to decline to cover the full costs of Mr B's proposed surgery?

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr and Mrs B and WPA. Section one of the contracts says that the purpose of the policy is:

'To indemnify you for the customary and reasonable cost of elective, short-term, eligible treatment for acute conditions.'

Page five of the contract includes a section called 'Your treatment provider's fees'. This says:

We have cost and fee agreements with almost every hospital and we publish our schedule of fees for Specialists – these may be viewed at any time at www.wpa.org.uk/guideline.

Fee reimbursement levels are set by us at a level of customary and reasonable cost by means of our continuing dialogue with the medical profession. For the vast majority of cases, this results in your treatment provider's fees being reimbursed in full.

Very occasionally, a Specialist may charge you more than we consider to be the customary and reasonable cost and if you decide to proceed then it is your responsibility to settle the difference. We refer to this as a shortfall.

The policy benefit memorandum of November 2023 (which replaced the original policy definition) defines 'customary and reasonable cost' as follows:

'The level of fees for a consultation or procedure that we deem to be customary and reasonable cost. In assessing the customary and reasonable cost of a procedure we consider the complexity of a procedure and the time and skill involved in its performance. Our fee levels as set out in our Fee Schedule are regularly reviewed by WPA's Medical Advisory and Clinical Governance Committee, whose medical members have both private and NHS consultant experience. We take professional advice from our Specialist advisers and through continuing dialogue with both the medical profession and professional specialist bodies.'

WPA has accepted liability for Mr B's claim and indeed, it's paid for ongoing treatment for his condition for over four years. But that doesn't mean it's responsible for paying for all and any of his treatment costs. WPA's fee schedule states that the maximum it will pay for Mr B's particular procedure code is £1800. Under the terms of the policy, that's the limit of WPA's liability for the surgery. However, Mr K has quoted a cost of £5800 for the operation. So, in line with the contract terms, I think WPA is reasonably entitled to limit its contribution to the surgery to £1800 and to conclude that Mr and Mrs B are liable for the shortfall in the balance.

Has WPA provided Mr and Mrs B with clear, fair and not misleading information?

In my view, the policy terms make it sufficiently clear that WPA will only pay what it believes to be customary and reasonable fees for a specific type of treatment. I'm also satisfied that WPA's website clearly sets out the fees it will pay for various procedure codes – including the bilateral hip replacement Mr B was booked in for. This information is readily accessible

online. And I find that the definition of 'customary and reasonable cost' explains the factors WPA takes into account when it determines what fees should be. I'm also satisfied that the name of the chair of the Medical Advisory and Clinical Governance Committee and their medical qualification can be found on WPA's website. So I think WPA has provided sufficiently transparent information both about the Committee and how the policy works.

While Mr and Mrs B now complain that the policy was mis-sold to them, this isn't a complaint point they previously made to WPA, so it would be inappropriate for me to comment on the contract sale specifically here. But in more general terms, I don't find the policy information to be unclear, unfair or misleading. As I've explained, I think the contract terms clearly set out what's covered and state that if the costs of treatment exceed what WPA believes to be a customary and reasonable cost, a policyholder will be responsible for meeting any shortfall in the cost of that treatment. And I find that a policyholder can generally choose their own specialist, with WPA meeting any of their charges which fall within its fee schedule. I don't find the policy to be misleading on this point. It was open to Mr and Mrs B to cancel the policy if they didn't think it was right for them.

I'd add too that in my experience, most, if not all, private medical insurers include similar terms in their policies and limit what they'll pay towards treatment to fees they consider to be customary for that particular consultation or surgery. Indeed, WPA told Mr and Mrs B that its fee for bilateral hip replacements was significantly more than its competitors would pay. So even if I had felt the policy terms could have been worded more clearly, I'm not persuaded that Mr and Mrs B could have found a policy which worked substantively differently.

It's clear that Mr and Mrs B feel strongly that WPA should have informed them about the potential for Mr K to uplift his fees at the outset of their claim. I've considered this carefully. When Mr B's claim was first authorised, it appears he was under the care of another specialist. I've seen no persuasive evidence that WPA was aware at that point that Mr B would definitely need surgery. And while Mr B went on to consult with Mr K and then undergo treatment in 2022 and 2023, it seems the costs of those treatments and consultations were fully covered by WPA's fee schedule. It also seems that Mr B underwent physiotherapy, chiropractic treatment and injections in the years before surgery was scheduled. So it isn't at all clear to me that WPA could have known or ought reasonably to have known that Mr B would definitely require hip replacement surgery. WPA also says that Mr K had previously charged within its fee schedule for the particular procedure, so I can't reasonably say it would have known what Mr K's overall fee would be at the point Mr B needed surgery.

I can also see that each of the claim authorisation letters WPA sent Mr B from June 2021 included the following section:

'***Protecting your interests***

Consultants are under an absolute obligation from their professional bodies to tell you in advance what their procedural charges will be.

We settle surgeon and anaesthetist fees up to the limits within our Professional Fee Schedule…

Sometimes, a consultant may charge more than our Professional Fees level, as they are free do, and if you agree to these additional charges it is your responsibility to settle the difference.'

Again then, I think WPA's correspondence with Mr and Mrs B made it clear enough that if treatment costs exceeded its fee schedule, a policyholder would be responsible for the

shortfall.

I'm mindful too that the policy requires a policyholder to gain pre-authorisation from WPA before they arrange treatment. In this case, Mr and Mrs B didn't obtain pre-authorisation ahead of arranging the surgery. So I don't think WPA had an opportunity to inform them about the potential shortfall in the surgery costs before Mr B decided to book the operation in with Mr K. I can't fairly hold WPA responsible for Mr and Mrs B's choice not to ask WPA for pre-authorisation.

And I've also borne in mind that Mr and Mrs B complained about the surgery cost shortfall in March 2024. This was around nine months before the surgery was due to take place. I can understand why Mr B wanted to remain under Mr K's care, given he'd been receiving treatment from Mr K for some time and given Mr K's experience. But I think it was open to Mr and Mrs B to ask for information about other specialists who did charge within its fee schedule. While Mr and Mrs B say WPA hasn't provided them with such a list of specialists, this wasn't something they requested in their original complaint to WPA and it isn't clear that WPA has been given a chance to provide them with this information.

Conclusion

Overall, I sympathise with Mr and Mrs B's position because I appreciate Mr B suffers from a condition which causes him a great deal of pain and which has impacted on their day-to-day lives. I also understand that paying the shortfall balance will have a real impact on their financial situation. But I don't think WPA acted unfairly when it assessed their claim and I find it's reasonably entitled to limit its liability for the surgical costs to £1800. So this means I'm not telling WPA 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 Mr B and Mrs B to accept or reject my decision before 20 December 2024.

Lisa Barham
Ombudsman