Before the Arbiter for Financial Services

Case No. 056/2019

TO ('the complainant')

vs

Axeria Insurance Ltd. (C 55905)

('the service provider'/'the insurer')

Hearing of 21 October 2020

The Arbiter,

Having seen the complaint whereby the complainant submits that he currently has a hip condition affecting his hips bi-laterally and specific procedure is needed to rectify the problem. He argued that despite April UK accepting this diagnosis and have authorised the required procedure for both hips, his policy expired in June 2019 with April UK/Axeria not renewing it after this date as they are pulling out of the UK market.

He claimed that in 2017, he enquired with April UK and Healix Healthcare (these being the claims handlers) about having his hips operated. They approved a re-assessment of the condition that they had already authorised in 2014. The complainant submits further that following his consultation with Professor SE, he had issues with April UK and Healix to get the authorisation approved, with the cause of delay being that April UK failed to obtain his records dating back to 2014 from EMR, the company handling the claims at the time.

The complainant argued that due to the loss of such medical data, he was required to go again through re-assessment before gaining re-approval leading to the expiry of the policy. Although he could potentially have one hip operated

before the expiry of the policy since it is a medical requirement to leave several weeks pass between each hip operation, it was no longer possible to have both hips operated before the date of the expiry of the policy.

The complainant insisted that since his medical condition was fully pre-diagnosed and approved prior to the expiry of the policy, both procedures including all aftercare and related medical care should be paid for by the service provider regardless of when the cover expired.

Thus, he pretends that April UK/Axeria pay in full for both his hip operations including all aftercare, physiotherapy, follow up consultations, and any further treatment deemed necessary that relate to the current condition on both hips, that is, Femoral Acetabular Impingement.

Having seen the reply of the service provider which states that:

From the complaint filed with the OAFS dated 8 July 2019 and the documentation enclosed therewith (the 'Complaint'), it transpires that the basis for the Complainant's request for the above-mentioned compensation is linked to the Company's careful decision to withdraw from the UK Private Medical Insurance market, in the sense that the Company is no longer offering or renewing Private Medical Insurance in the UK.

In the meantime, medical interventions or medical treatment could not continue to be paid out to the Policyholder under the Private Medical Insurance plan insured by Axeria Insurance Limited since Axeria Insurance Limited did not renew Mr TO's Private Medical Insurance Plan when it expired at the end of the Policy's one year term.

In this regard, the Policy terms and conditions, on page 15, clearly state:

"This policy provides benefit for treatment incurred during the policy period only. In the event that this policy is not renewed the insurance will cease paying for expenses incurred after the expiry date."

Therefore, whilst a procedure may be eligible for benefit, the treatment must have taken place during the Policy period and before the expiry date.

In his complaint, Mr TO is also stating that the cause of the delay in the carrying out of the hip operations and, therefore, not being in a position to carry out both

operations within the Policy period, was caused by a delay from Axeria Insurance Limited/April UK in obtaining the Policyholder's records dating back to 2014 from a claims handling company called EMR which processed claims at the time.

The service provider submitted that the Company's claims handlers, Healix Health Services, required further clarifications of the Member's symptoms. Mr TO's original claim with EMR was opened for "*left leg pain*" whereas Mr TO was currently claiming for symptoms relating to both hips and not just the "*left leg pain*". There is no relationship between the time factor and the transfer of medical records from EMR, and this was clearly explained to Mr TO in various correspondences.

On the other hand, it is pertinent to highlight that under Mr TO's Policy terms and conditions, the insurer has the right to require further medical reports, in accordance with the text on page 13:

IMPORTANT INFORMATION WHEN MAKING A CLAIM

We may ask you to provide information to help us assess your claim. For example, we may ask you for one or more of the following:

- *Medical reports and other information about the treatment for which you are claiming. If we request a medical report from your specialist and they charge for providing this we will pay the cost.*

[…]

- *A referral letter and/or medical notes from your GP*.

The service provider further stated that initially Mr TO did not approve the release of information from his medical advisors. At this time, Healix Health Services even received a response from the relevant Professor's secretary that she had been instructed not to release the historical medical reports related to Mr TO. The medical information was eventually received on 29 April 2019, and the decision regarding Mr TO's claim was taken on the same day. On 29 April 2019, Healix Health Services attempted to call Mr TO to provide him with the decision. As they could not reach Mr TO, Healix Health Services delivered the decision on the claim to his broker who, understandably, then contacted Mr TO directly.

The Company's position is therefore such that the Complainant's request for compensation is without doubt not justified and should not be upheld as the Company fulfilled all its obligations under the Policy and, accordingly, the Company should not be held liable to pay any compensation to the complainants and any costs relating to the Complaint.

Having seen the statements and the evidence submitted by both the complainant and the service provider,

Further Considers

Merits of the case

The main issue being contested in this complaint is that the insurer is refusing to pay for the hip operations which the complainant needs to undergo. As a result of the service provider's withdrawal from the UK insurance market, the complainant's policy was not renewed and hence the insurer held that cover was no longer possible. The complainant submitted that despite the medical intervention was authorised in 2014, a re-assessment was required and there was a delay due to April UK failing to obtain his medical records from the previous claims handler.

The complainant insists that since the condition was fully pre-diagnosed and approved prior to the expiry of the policy, both hip procedures, including all aftercare and related medical care, should be paid by the insurer, regardless of when the insurance expired.

On the other hand, the service provider argued that the policy provided benefit for treatment incurred during the policy period only and considering that such policy will not be renewed, medical interventions or medical treatment could not continue to be paid out.

It was also noted that, as per policy terms and conditions, the insurer had the right to require further medical reports.

The Arbiter shall determine and adjudge the complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[1]

In the original complaint form submitted, the complainant submitted that April UK, the insurance brokers in the UK, had previously accepted his diagnosis and authorised the procedure to be conducted on both his left and right hips. When contacted again in 2017, a re-assessment of the condition which they had originally authorised in 2014 was approved. As a result, he consulted again with Professor SE in 2019.

Timeline of important events concerning this case:

- *18 June 2013* – As per the various Certificate of Registration[2] submitted, this is the commencement date of the complainant's Private Medical Insurance.

- *2 August 2014* – Clinic note[3] written by Mr HN – Consultant Orthopaedic Surgeon, whereby it was submitted that on 30 July 2014, the complainant had presented himself with multiple problems affecting both legs. At that time, Mr HN was not entirely clear of what was causing the complainant's ongoing pain and referred him for some tests, x-rays, MRI scans, and ultrasound scans.

- *8 August 2014* – Document[4] issued by EMR Services, the claim handlers of the service provider at the time, whereby it was confirmed that *"… subject to the terms and conditions of your policy this treatment will be eligible for benefit."* This was in relation to claim number 10784159-0 with the condition being *"Left Leg Pain"*.

- *19 September 2014* – Clinic note in relation to another consultation with Mr HN, Consultant Orthopaedic Surgeon on 17 September 2014. It was reported that although the blood tests returned as normal, they discussed findings together with some of the treatment options. One option was to

[1] Cap. 555 of the Laws of Malta, Art. 19(3)(b)
[2] *A Fol.* 196
[3] *A Fol.* 189
[4] *A Fol.* 188

consider an arthroscopy to the left knee where there was an 80-90% chance that it would improve some of the pain. However, the complainant was not sure whether his symptoms in his left knee were bad enough to require surgery and had some time to consider his options. It was also submitted that should the complainant decide not to proceed with a left knee arthroscopy, he would be referred to Professor SE for possible hip impingement.

- *14 January 2015* - Clinic note in relation to a further review[5] of the complainant's condition carried out by Mr HN on 13 January 2015. The main issue was pain around his "*left great toe MTP joint*".

  It was submitted that the complainant was *"… not keen on any kind of surgery due to the amount of time required off work"* and liked to try an image guided steroid injection for which he was referred. He also complained of pain in both hips and as a result of the x-rays carried out in August of the previous year that were suggestive of hip impingement, the complainant was referred to Professor SE for his advice.

- *4 February 2015* - Consultation[6] with Professor SE – Consultant Orthopaedic Surgeon with specialisation in shoulder and hip arthroscopy, groin and sports injuries. The complainant presented himself with stiffness of his hips and occasional pain. A 3D CT scan of both hips was carried out and various issues resulted. As a result, he was provided with a hip arthroscopy booklet and *"… has gone away to think about matters further."*

- *2017* - Complainant stated that he contacted April UK and Healix to make enquiries about having his hips operated.

- *20 March 2019* - A further consultation[7] with Professor SE whereby an analysis of a recent 3D CT scan was carried out.

[5] *A Fol.* 193
[6] *A Fol.* 194
[7] *A Fol.* 195

- 8 May 2019 - April UK informs the complainant that they had confirmed the procedure for his hips provided it was booked prior to the 17 June 2019.[8]

- 30 May 2019 - Pre-authorisation certificate sent by April UK to the complainant confirming that they had authorised the treatment which was booked for the 6 June 2019 at the ____ Clinic. The pre-authorisation certificate was valid for 30 days.[9]

- 3 October 2019 - Communication[10] sent from April UK to the complainant advising of non-renewal of private medical insurance plans due to the insurer deciding to withdraw from UK Private Medical Insurance market.

Further considerations

The complainant insists that his diagnosis had already been accepted and the procedure had been authorised in 2014. The Arbiter notes that the only proof held on file in relation to a claim for treatment being authorised by EMR in 2014 was that dated 8 August 2014.[11] The condition listed in this approval was *Left Leg Pain.* There is no further indication or information related to such claim approval. The only relevance of this fact is that, contrary to the impression that the complainant wants to convey, in 2014 no approval was given regarding his hips which are the only subject of this complaint.

Then the complainant noted that in 2017, he contacted April and Healix Healthcare to enquire about having his hips operated, whereby a re-assessment of his condition was approved. Despite insisting that the delay in authorising his claim and the relevant treatment required was due to April UK failing to obtain his medical records dating back to 2014 from EMR, the Arbiter notes that, as admitted by the complainant himself, it was in 2019 that he consulted again with Professor SE for a re-assessment regarding his hips.

From the email correspondence that has been submitted, the Arbiter understands that the main issue delaying the approval for treatment was the

[8] *A Fol.* 19
[9] *A Fol*. 125
[10] *A Fol.* 229
[11] *A Fol.* 188

request for GP referral, which despite various requests by Healix, the complainant failed to provide. This is confirmed in an email dated 18 March 2019.[12] This request was made prior to the latest consultation with Professor SE on 20 March 2019.

Upon receipt of the clinic report following such consultation, Healix confirmed that:

"Whilst I can certainly see the clinical need for the right hip to undergo so surgery and at this stage the Professor has indicated an Arthroscopy this letter alone does not satisfy the underwriting of your policy and therefore does not allow us to complete assessment of cover."[13]

Then, on 18 April 2019, Healix advised that:

"I have submitted the request for the GP history today."[14]

On 8 May 2019, the complainant was informed that:

"Please take this email as confirmation we are happy to confirm cover for your procedure, so long as this is booked in prior to your lapse date 17/06."[15]

Then, his *"… operation is tentatively booked for Thursday 6th June."*[16]

Healix then issued a *Pre-authorisation Certificate*[17] dated 30 May 2019. This confirms the date mentioned by the complainant, that is, 6 June 2019, and the procedure to be carried out being:

"Arthroscopic femoro-acetabular surgery for hip impingement syndrome, W1380 - Arthroscopic femoro-acetabular surgery for hip impingement syndrome, T8003 – Major release of muscle for pain or contracture (e.g. Quadriceps) (involving large joint)."

This pre-authorisation was valid for 30 days and subject to all other policy terms and conditions.

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[12] *A Fol.* 165
[13] *A Fol.* 162
[14] *A Fol.* 151
[15] *A Fol.* 19
[16] *A Fol.* 13
[17] *A Fol.* 125

However, despite this pre-authorisation, it resulted that this scheduled procedure did not take place.

The complainant explained that:

"The initial date for the operation was cancelled due to the surgeon being taken ill. The rescheduling for the operation won't be until after the expiry of my policy with April. The cancellation of the operation was not my fault, and April have already agreed to pay for this operation."[18]

To this, the service provider replied that:

"The policy wording state: 'This policy provides benefit for treatment incurred during the policy period only. In the event that this policy is not renewed, we will cease paying for expenses incurred after the expiry date.'. In light of this, we regret to inform you that if the treatment is incurred after the expiry date we cannot cover the claim."[19]

The service provider argues that:

"We withdrew from the market, so we do not cover claims that come after that."[20]

The Arbiter notes that at this stage, the insurer is refusing to compensate the complainant solely because the treatment would have been received after the expiration of the policy, that is, after 17 June 2019.[21]

The service provider quotes the policy document[22] submitted with the reply to the complaint.

With reference to the policy document, the complainant argues that:

"I noticed changes in their policy documentation that I think they made changes in order to make that transition smoother for them. That meant that existing clients suffered disadvantages, the main one being that if an illness is diagnosed during the policy period and then the policy expires before the treatment is

[18] *A Fol.* 16
[19] *A Fol.* 10
[20] *A Fol.* 354
[21] Renewal date was 18 June 2019.
[22] *A Fol.* 326

conducted, Axeria created this scenario where they simply could get out of the responsibility of paying the clients. It is reflected in the latest documentation that I have."[23]

However, in this respect, the Arbiter does not have adequate proof to come to the conclusion that Axeria changed the policy document to avoid claims. The documents submitted by the complainant in this respect are not adequate to prove this point because previous policy documents submitted by the complainant are not dated and the service provider is not listed as the insurer/underwriter in all of the mentioned policies.

Therefore, the Arbiter is not accepting this argument submitted by the complainant.

However, as to the merits of the case, namely, whether the service provider should honour the claim and pay for the hips' procedures, the Arbiter has to decide the case with reference to what, in his opinion, is *fair, equitable and reasonable in the particular circumstances of the case.*[24]

The Arbiter has a different view to that submitted by the service provider in refuting the claim to pay for the complainant's hips' operations.

In its reply, the service provider quotes one of the General Rules on page 15 of the policy document which states:

*"This **policy** provides benefit for **treatment** incurred during the **policy** period only. In the event that this **policy** is not renewed, **we** will cease paying for expenses incurred after the expiry date."*[25]

The Arbiter notes that the service provider is quoting this section of the policy out of context of the events that took place in this particular case. The Arbiter is bound by law to decide the merits of the case according to **the specific circumstances of each case.** [26]

[23] *A Fol.* 353
[24] Chapter 555 of the Laws of Malta, Art. 19(3)(b)
[25] *A Fol.* 340
[26] Cap. 555, Art .19(3)(b)

In this case, the pre-authorisation certificate was issued on the 30 May 2019, whereas the policy had to expire on the 17 June 2019, meaning that it was issued *prior to the expiration of the policy* and when the policy was still in force.

The pre-authorisation was valid for 30 days, that is, until the 29 of June 2019 when the policy cover would have already expired.

The same pre-authorisation document stated that the complainant had to book the operation for a date prior to the expiration of the policy on 17 June 2019. As has already been established in this decision, the complainant complied and booked the operation for the 6 June 2019.

However, for reasons beyond the complainant's control, the operation was not conducted on that date because the surgeon fell ill.

Moreover, although the service provider is claiming that its refusal to pay for the operation is due to the fact that the expenses are to be paid outside the policy period, the insurer itself had authorised such a contingency when it authorised the procedures to take place outside the policy period.

The pre-authorisation document covered the expenses beyond the policy period since it was valid till the 29 June 2019, whereas the policy expired on the 17 June 2019.

This also means that the pre-authorisation document was considered by the same service provider not to be in conflict with the General Rules of the policy as quoted above.

Hence, the service provider itself was considering a scenario that the treatment could be carried on ***beyond the policy expiry date***. The Arbiter understands that the service provider took this reasonable step because it considered the pain suffered by the complainant, the relevant consultations, and that the claim submitted to the service provider was made when the policy was still in force. Considering that the claim for benefit was confirmed twice by the service provider and was also considered to take place after the expiry date of the policy, the insurer had surely made the necessary reserves to pay for such claim.

The Arbiter is conscious of the fact that in various jurisdictions the pre-authorisation certificate may have different connotations. Sometimes it is

confused with *pre-certification*. However, there is a clear difference between pre-certification and pre-authorisation. Pre-certification is normally the permission given by the insurer to the hospital or clinic to render the service to the insured but, up to that stage, there is no guarantee of payment.

On the other hand, pre-authorisation is generally considered to be a step further, namely, it is a written statement given by the insurer to the insured, or to the hospital, stating that they are approving the treatment and implying a guarantee for payment. However, each case has to be considered on its specific circumstances and merits because the wording of such promises might be different, and the circumstances of the insured can vary from case to case.

In this case, the wording of the pre-authorisation certificate is clear that the insurer had authorised the procedure, entered into the details of its performance and this is corroborated by the email sent by the service provider to the insured dated 8 May 2019.[27]

Furthermore, the Arbiter firmly believes that the contract of insurance is a bilateral contract, and based on the principle of *uberrimae fidae*, where each party is bound to honour its part of the obligation. Whilst the insured is obliged to pay the agreed premium scrupulously and to disclose all material facts that might influence the premium or the refusal of cover, on the other hand, the insurer is obliged to deal with claims in a reasonable and fair manner.

In this case, in order for the insurer to act fairly and reasonably, it has to accept the fact that the medical intervention did not take place within the suggested period because of circumstances beyond the control of the complainant, namely, the unavailability of his surgeon due to illness.

Once the service provider had committed itself to pay for the medical procedure, and the complainant booked the operation as was told by the insurer within the time frame suggested, and everything was in place for the operation to take place on the 6 June 2019, the complainant should not be blamed and lose the benefit of the cover simply due to unforeseen circumstances over which he had no control.

[27] *A Fol.* 19

To be acting fairly, the insurer should honour its pre-authorisation commitments and pay for the treatment it so authorised.

For the above-stated reasons, the Arbiter decides that the complaint is fair, equitable and reasonable and is accepting it in so far as it is compatible with this decision.

In accordance with Article 26(3)(c)(iv) of Chapter 555 of the Laws of Malta, the Arbiter orders Axeria Insurance Ltd to pay for the expenses incurred/or to be incurred by the complainant for the procedure as authorised in its email of the 8 May 2019,[28] and confirmed by the pre-authorisation certificate of the 30 May 2019.[29]

With legal interest at the rate of 8% *per annum* from the date of this decision until the effective date of payment.

The costs of these proceedings are to be borne by the service provider.

Dr Reno Borg
Arbiter for Financial Services

[28] *A Fol.* 19
[29] *A Fol.* 125