The land of confusion

When an employer starts thinking about providing medical insurance for their staff, their main concerns are cover and cost. But things aren't that simple for them or for intermediaries, like Debbie Kleiner-Gaines of Best Health UK

Medical insurance intermediaries are increasingly having their work cut out to make sure they have looked after their clients best interests. And if they find things hard, heaven help the employers who go direct to the insurer.

Medical insurance intermediaries are finding that three crucial elements of medical insurance are becoming ever harder to explain. How easy is it to make a claim? Will every claim be paid in full? Are there any limits on cancer cover?

The group administrators in large companies are often dedicated members of staff with plenty of experience handling claims. However, because managing directors and HR managers in smaller companies rarely have this experience, they tend to turn to intermediaries like me for help.

Yet with all my experience, even I find it less than straightforward to find written explanations on how the claims process works. And if I find this difficult, and understand all the jargon, how can the insurers expect my clients to cope?

It seems that there is a general lack of transparency when it comes to some areas of medical insurance, which means clients often do the wrong thing and then they (or more usually I) have to spend time sorting it out.

The classic mistake is to assume that everything will be paid for, and to go ahead with treatment. It is not until later that clients realise that they should have taken the list of insurer-approved hospitals in with them when they went to see their GP, and then phoned to get the go-ahead from the insurer. Unfortunately, not all insurers' handbooks and brochures make this patently clear.

All intermediaries accept that having trouble with claims from time to time is a fact of life. However, the people who are ill find such situations highly stressful. Yes, all insurers have customer telephone helplines, but as with everything, people are only likely to get the answers they need if they know what questions to ask.

The biggest problem area for my clients is around specialist fee guidelines. People often assume – wrongly – that common procedures will not require advance permission. Here, too, the specialist fee situation can cause confusion. Two of my clients, both busy managing directors, have had fairly typical experiences. Both had major shortfalls in payments from their insurer.

When the first client wrote to his insurer to complain, they replied that he should have asked for a list of their specialist fee guidelines. He had made the common assumption that if a hospital is on the approved list, the fees of all the specialists who work there would acceptable, though this is not always true.

The second client is fairly typical of a busy managing director, in that he did not bother to read the brochures – "I don't read brochures, I take advice" was his comment. He went on to say that, since the advice he took was on who to go with for "comprehensive" insurance, he was now less than happy.

The result? I have an unhappy – and possibly lost – client. The fact that I, like any good intermediary, originally pointed out that there could be shortfalls is immaterial. At the end of the day, he acted like most busy people and made assumptions based on the word "comprehensive".

I now warn my clients that they must check with me before proceeding with any treatment. What's more, I have reworded my standard letters to ensure clients have been warned of this possibility.

When I asked the insurer about these cases, they pointed out that their handbook explains: "customers should call us to check that their specialist and hospital fees will be covered; we will tell them how much we will pay towards the cost of their treatment so they can determine whether they need to pay anything themselves."

In fairness, they also said that both these clients had been told that there would be shortfalls before they went ahead with their treatment, but opted for their chosen specialist anyway because their GP had recommended him.

I discussed this issue with various insurers, including Norwich Union Healthcare, who remarked that they are often asked if they can give a list of specialists. However, there are potential liability problems attached to such recommendations, as well as matters of clinical judgement, involved here.

They also emphasised that such shortfall situations are, in their experience, the exception rather than the rule. Of the specialists on whom they hold details, less than 20% charge more than the insurers' fee guidelines, and these guidelines are reviewed at six-monthly intervals. Norwich Union Healthcare went on to say they welcome any initiative on obtaining greater clarity.

The two cases described above were not cancer cases, but it is with these that there is currently most dissatisfaction. I recently had one client with cancer who found herself in an NHS bed and wanted to move to a private hospital.

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The whole process took ten days: for the form to arrive from the insurer, for the form to be signed by her GP to say that the diagnosis was not an exclusion (stomach disorders), for the insurer's chief medical officer to check that the drug the specialist wanted to use was not on the excluded list (either a palliative drug or one that was on trial), and for the insurer to give the final OK. That was ten stressful days for the patient and her family.

The charity Cancerbackup stated in an article in their own newsletter back in 2005 that they believed health insurers were failing cancer patients. They said insurers often withdrew funding for vital treatment and misled patients about the type and extent of care their policies cover, and exactly what medication was covered, especially where secondary cancers are concerned.

Since then, the charity has worked with the Association of British Insurers (ABI) on its new Statement of Best Practice on Selling PMI. However, while the charity feels this statement is a vast improvement, it still doesn't go far enough.

"The key improvement," says John Cox, senior PR and campaigns officer for Cancerbackup, "would be for insurers to adopt a definition of 'active treatment' for cancer rather than classifying cancer as either an acute or chronic condition."

Cancerbackup's definition of active treatment is: "treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it or slowing the spread of the disease and not given solely to relieve symptoms".

"For example," Cox continues, "a patient with prostate cancer maybe told by insurance companies that this is a 'chronic condition', as the patient may live for many years with little change to the tumour. However, treatment for the tumour may be possible, although it may be to shrink the tumour and prolong life rather than curative treatment. Under the definition "active treatment", a patient would be entitled to receive this treatment, whereas they would not be covered by a "chronic" definition.' Cancerbackup continues to lobby the ABI on this.

As it happens, some insurers are addressing the issue of transparency by reviewing their policy wordings and documents, but as far as we know, only a handful are doing this.

It is time for intermediaries specialising in medical insurance to work together on this, perhaps via the Association of Medical Insurance Intermediaries. Together we should be able to work out some kind of common method for comparing/contrasting policies. To help us, we need information. Here are some questions I would ask the insurers, based on my own experience:

- What percentage of claims are authorised over the phone?
- How many claims have suffered shortfalls in the past year due to your specialist fee guidelines clauses?
- How often do you update your fee guidelines?
- At what point do you define cancer as a chronic condition?

Most insurers are aware that more transparency can only be a good thing, and are willing to work on this. However, they need to provide a standard format to make more elements of the cover clearly communicable to our clients. That will make life easier for the clients, and make it easier for intermediaries who have to provide these explanations to their clients.

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