

BMA



Guide for patients thinking of taking out Private Medical Insurance



British Medical Association
bma.org.uk

Introduction

The NHS is the UK's state health service which provides treatment for UK residents. Some services are free, others have to be paid for.

People who are 'ordinarily resident' in the UK are eligible for free NHS treatment in all settings, including at GP practices, hospitals, and other services. Patients are usually referred to a consultant when their GP thinks it is necessary to be referred for a second opinion. GPs are responsible for referring patients to hospital-based specialists.

A person is 'ordinarily resident' for this purpose if lawfully living in the UK for a settled purpose as part of the regular order of his or her life for the time being.

The following NHS treatment is available to anyone:

- Treatment in an emergency (but not follow up treatment).
- Treatment of certain communicable diseases.
- Compulsory psychiatric treatment.

For more information on entitlement to NHS care and exemptions to NHS charges, please see the [BMA guidance on access to health services for overseas visitors](#).

Some patients however choose to buy private medical insurance, whilst others become automatically insured via their employer (as a benefit of their employment). Private medical *insurers* are insurance companies that provide particular health *insurance policies* which cover payments of benefits as a result of sickness or injury. This guidance focusses on the information and key points you should consider prior to purchasing private medical insurance.

Reasons for taking out insurance

The purpose of Private Medical Insurance (PMI) also known as Private Health Insurance is to assist you in paying for private medical care and treatment for short term, curable conditions when you need it. The alternative being to pay for care yourself as the need arises ("Self-pay").

It is crucial that the PMI cover you buy, ensures the following when you need treatment:

- That you have insurance cover for the conditions for which you may require treatment
- That you have, in conjunction with your GP, free choice of Consultant with the right to top-up fees if they exceed the insurance reimbursement.
- That you have the option of choosing the hospital where you receive treatment and if necessary are able to top-up the charges if you require to use a hospital that charges more than your insurance cover.

Choosing the right plan for you will depend on your budget and the level of cover you select to meet your needs. You need to be confident that the cover you are buying will cater for your needs. The exact details of what is covered will vary considerably from policy to policy.

What questions should you ask of insurers?

The BMA Private Practice Committee has put together this guide to outline the fundamental questions you need to ask the different Private Medical Insurance providers and yourself before making an informed decision. This guide has been reviewed by the Patients Liaison Group (PLG) at the BMA, for the benefit of patients. The PMI market is a large one, so please always shop around until you find a cover that suits you best.

1. What Benefits Are Included?

You should consider what you want PMI to cover for your particular needs. Most PMI providers have a range of different products and you will need to think carefully before you decide. Here is a list of areas you may want to consider:

- Consultation Fees (is there an annual limit?)
 - In-patient and day case hospital care
 - Imaging (is there an annual limit)
 - Laboratory tests (check annual limit)
 - Second opinions
 - Oncology cover
 - Physiotherapy.
 - Rehabilitation services. *
 - A & E visits *
 - Organ transplants *
 - Fertility treatment or normal pregnancy *
 - Non-essential cosmetic treatments *
 - HIV or AIDS *
 - Dental Care*
 - Preventive services (such as immunizations and mammograms) and management of chronic diseases such as diabetes. *
 - Prescription drugs*
 - Mental health conditions*
 - Drug dependency*
 - Routine check-ups from a GP *
 - Cancer Care (Most companies cover chemotherapy, radiotherapy and surgery in full and some pay for the long-term biological therapies used post treatment to boost the immune system for as long as they are required. However, some companies will only pay for these drugs for 12 months. It is prudent to ask questions around limits relating to cancer treatment and follow up)

Most PMI policies do not provide cover for the areas marked by an asterisk.

2. What are the different types of health insurance?

There are usually three types of cover:

Moratorium underwriting

- a. Moratorium underwriting works to the 5 and 2 rules – this implies that any conditions you have had in the last 5 years will not be covered for 2 years. Providing that you are treatment free in that 2-year period, you then become eligible for cover.

Full medical underwriting

- b. Full medical underwriting allows the insurer to have a more detailed look at your medical history. Pre-existing conditions of an acute nature from 4 or 5 years ago are not normally a problem and will be covered. However, something of an acute nature in the last 1 or 2 years will generally be an exclusion and would be eligible for review after 1 or 2 years. The insurer may contact your doctor, with your consent, to obtain further information if required. For patients over the age of 75, most insurers would offer full medical underwriting only.

Switch Underwriting

- c. Switch underwriting is designed for patients who are already insured but wish to transfer with pre-existing conditions subject to a few questions. It is sometimes more expensive due to the greater risks for the insurer.

Other types of health insurance

- d. There are also various specialist policies available, such as those for over-55s or ones that focus on particular diseases. Others only provide cover if you are forced to wait longer than six weeks to receive treatment from the NHS.

3. Does the policy have any exclusions?

Policy exclusions are the conditions that the policy will not cover.

- Some insurance policies do not cover treatment of certain diseases in the first year but do cover them after a waiting period.
- The exclusions in the policy may differ from one insurer to another, therefore being aware of these exclusions is equally important as that will help you decide which policy to buy.

Important exclusions

PMI generally does not cover emergencies or chronic conditions. For example, if you suffer chest pains requiring an urgent admission to hospital, your PMI provider may not cover it.

4. What will the PMI cover/not cover?

Acute conditions

Generally, cover from a PMI provider is offered to patients with acute conditions; that is illnesses that come on suddenly (but are not emergencies) and can be treated promptly and in most cases cured. They are not designed for long term, or chronic conditions, which are far harder to cure and which may recur often throughout your life.

Elective surgery

Private medical insurance is designed to cover elective surgery – that is non-urgent operations that you need but that can be planned, such as a hip/knee replacement or a cataract operation. Most policies do not cover emergency surgery.

Chronic conditions

Similarly, if you have a chronic or “long-standing” condition such as Type 2 Diabetes, your PMI provider is not likely to pay for any investigations or treatment for that condition. However, if you suffer an acute medical problem indirectly related to it, you may get cover. However, PMI policies differ, and it is important to check carefully before choosing.

It is crucial that you read the small print of your policy to understand exactly what you are covered for and what is excluded.

5. Does the insurance policy cover you for care in any hospital, and if you are abroad?

Some PMI policies will not cover care in all private medical facilities in the UK or for treatment outside the UK, so it is very important that you know before travelling what is covered.

USA

This is important everywhere, but particularly if you are thinking about going to the United States, where you may need separate, additional cover because insurers are wary of the high costs of treatment in the USA.

EU

Other considerations include, understanding the situation within the EU and the situation in those countries where there is a reciprocal healthcare agreement with the United Kingdom.

6. What are the plan's restrictions on cover for pre-existing conditions?

- If you or someone in your family has a chronic condition, the policy may not cover related medical costs for a period of time or ever.
- Ask for how long pre-existing conditions are excluded.

7. Does the plan exclude specific conditions of illnesses?

Make sure you ask detailed, specific questions, and get answers in writing.

8. Will I have the freedom to choose the doctor I wish to see?

This is very important. There are schemes that restrict your choice and will recommend 3 consultants. The BMA does not approve of these restrictions and believes that best practice is when the patient is able to choose the consultant they want to see, assisted by their GP.

9. Regulation, revalidation and Practising privileges

Doctors' ability to practice is regulated by the General Medical Council (GMC) through a process of annual appraisals and 5-yearly revalidation. Their ability to practice in the hospitals and clinics where you see them is regulated by the local Practising Privileges Committees of those facilities. Both forms of regulation are rigorous tests of a doctor's fitness to practice and of their competencies.

Private Medical Insurers do not automatically recognise a doctor who may be licensed with the GMC and have practising privileges. Consultants need to complete an application and gain recognition from the main insurers (such as AXA PPP and BUPA) before they are able to treat patients insured with these insurers. This includes full GMC registration and a license to practice. The consultants do not have a contract with the PMI providers but a recognition agreement.

In recent years, insurers have only recognised doctors if they agree to the fee reimbursement levels laid down by that PMI provider. If the doctor you want to see is licensed by the GMC and has practising privileges but is not recognised by one or more private medical insurer you may want to ask the insurer to provide clarifications as to why he/she is not recognised. In some cases, they may be the best doctor for your particular problem and you should consider pressing the insurer to explain why you cannot see that specialist. Before you buy PMI cover you may want to ask the insurer for a list of the doctors and hospitals that are covered to help you decide if the insurance cover is right for you. Finally, ask yourself if you are you willing to switch insurers if yours isn't covered?

10. Where can I find out more information about doctors or hospitals?

There is a relatively new organization called the Private Health Information Network (PHIN), which you can find here – <https://www.phin.org.uk/>. You can find out more information about doctors and hospitals from this website.

11. Will I be given the choice to top up payments from my insurance policy to access treatment from a consultant if I feel that is the most appropriate treatment for me?

Many PMI policies guarantee you won't face the risk of any shortfall on your consultants' fees. The trade off for this, however, is that it normally means your PMI provider will offer you a restricted list of doctors who have agreed to keep their fees at the level that the insurer has dictated. This restricts your choice and may mean you are unable to see the doctor who may be most suited to help you with your problem. The recently introduced restrictions on top-up payments have limited patient choice and reduced consultants' ability to set their own fees based on the service that they provide. Doctors will provide you with information regarding charges and any potential shortfalls before treatment is carried out. The breakdown should include Hospital Costs, Drugs and Doctors fees.

12. How is the policy premium determined?

When it comes to determining the premium, you pay for your health plan, age is a major factor. Previous medical history and postcode also play a role in deciding your health premium. A variety of lifestyle or health related habits (behavioural factors) can have a major impact on a person's health. Behavioural and social issues that impact on health and consequently on your insurance policy, include alcohol, smoking, lack of physical exercise, poor diet leading to obesity or malnutrition and problems resulting from drug taking.

13. What is the maximum number of claims you can make in a year?

You must ask your insurer about your claim limit beforehand. You should also check on cost limits for consultations and investigations.

14. How much will I have to pay for the insurance cover?

Premiums vary considerably from one insurer to another, so you should get quotes from several companies or approach an intermediary for help. Make sure that the quotes are like for like. Ask if you get any discounts for extra members of your family insured with you.

15. How does the insurance company handle disputes over claims?

All insurance plans have procedures for appealing denied claims. Ask what the company's average turn-around time is for resolving claim disputes. If you are not satisfied by the response, then you can go to the Financial Ombudsman Service.

16. What are PMI managed care initiatives or clinical care pathways?

Managed care initiatives are the clinical care pathways that are decided by case managers and case management teams employed by PMI providers, when assessing your health problems. When you contact your PMI provider, please ask them if they will involve you in a PMI managed care initiative.

The BMA is concerned by the impact of managed care initiatives and clinical care pathways on the care that patients receive and believe these are an attempt to alter the way that consultants provide treatment to their patients. Managed care initiatives disrupt traditional clinically proven referral processes, for example by removing decisions about treatment pathways from patients and GPs to case managers and case teams. This compromises patient choice in the short term and quality of care for patients in the medium to long term as decisions about treatment are based on what is deemed to be cost effective and not what is clinically appropriate. These care initiatives undermine the clinical decisions of doctors which erodes the doctor patient relationship and have the potential to cause prolonged treatment pathways by attempting to apply a universal model rather than an individual holistic approach. Patients and consultants are often exasperated by these case management initiatives which often prove to be administratively burdensome and delay effective treatment.

17. Can I make a claim within the first few weeks of taking out my policy?

Pre-existing conditions will not be covered. Some insurers will not allow you to make a claim within the first few weeks of taking out your policy whereas others, cover you from the moment you sign the form for a new problem. Check when you will be actually covered by your policy.

18. What is the key thing to consider if I am switching PMI provider?

If you are switching insurers, make sure that they will offer what is called a 'no worse terms' policy and match your existing insurance. Otherwise any health problems that arose under your old policy could be classed as pre-existing conditions and excluded by your new policy.

19. Is there an alternative to PMI providers?

Instead of paying a PMI provider, you could save the money and become a self-pay patient. Self-funding patients can often get a better deal than insurance companies by going direct to the hospital, but make sure that you get an all-inclusive price for your procedure, so you aren't caught out by complications.

20. How do I complain about my PMI provider?

You should contact the customer service department with detailed information about your complaint. They should provide you with the complaints procedure and many will have an online form or a telephone number to call with your complaint. If you are not satisfied with the way your complaint has been addressed, you could also involve the ombudsman. The Financial Ombudsman is a free and independent service that mediates between customers and financial services companies.

21. No Claims Discount (NCD)

It is important to understand how much your premium can increase through a claim, so as not to be surprised by a 20 to 30 % increase at renewal. Not all schemes are NCD, which means they only increase through age and inflation. It is also possible to protect your NCD with some companies. It is therefore advisable to either have a scheme that has protected the NCD or one that is not an NCD scheme, so you are not penalized for claiming.

22. Other questions you might want to consider

- Does my policy have a limit on treatment costs?
- How long must I hold the policy before I can make a claim?
- How much no claims discount do I lose for each claim?
- How much will I have to pay towards each claim?
- Is there an extra charge for paying monthly?
- What are my options to reduce the price of my premium?
- Is there a cap on future price rises?
- If I do not make any claims will my premium still increase with age?
- Is there a no claims discount?
- Is the excess voluntary or compulsory?
- Is it cheaper to pay up front for this policy?

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