Member of the public 18

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INVESTIGATION INTO PRIVATE MEDICAL INSURANCE

I do not know exactly what evidence you are considering in your investigation into Private Medical Insurance, but would like to make you aware of my experiences as an individual consumer.

I have had private medical insurance at my own expense with Axa/PPP for over [✂] years. I used the insurance only once before [✂], since when I have had several [✂] problems. One is not fully-covered by my insurer and my "two years" of funded treatment expired in [✂]. Now the insurers will only pay if a flare-up requires surgery, so the situation is that I self-fund for check-ups in addition to paying monthly premiums, which I can only afford by having an excess on my policy.

1 UNFAIR FINANCIAL ARRANGEMENTS

I am greatly concerned about the very unfair aspects of financial arrangements.

1.1 Restrictions on direct settlement between insurer and hospital. Although I am insured with Axa, I am actually held personally liable by healthcare providers for payment. Most consultants at [✂] Hospital will not deal direct with Axa/PPP for outpatient consultations. Charges have to be paid by the patient on the day and claimed back. [✂] will bill insurers direct for expensive surgery, but minor surgery has to be paid for upfront also, often **before** the treatment has actually been given. The finances take a very hard hit.

1.2 Continuing Errors. I have experienced horrendous errors between the insurers and the hospital over what has been paid and when. I have no entry into either Axa/PPP's Accounts Department or that at [✂], but have to say that both appear incompetent. I am caught in the middle and very angry, as administration **never** improves.

a) Payments from Axa: Conversations about payments can resemble pantomime dialogue: **Me:** "Axa say they have paid you"; **Hospital**: "Oh no they haven't; **Axa:** "Oh yes we have". **Hospital:** "Oh no they haven't". Etc, etc, etc.

b) Invoices from Hosptial to Axa: Another variant concerns invoicing, with Axa claiming that the hospital has billed incorrect amounts whereas the hospital insists otherwise. I have had to try to sort out amounts/dates paid when I have no idea how/when invoices have been prepared or submitted. I do not work for Axa or [✂], but they expect me to sort out problems of their making without my having access to any of their records.

2 FEE CAPPING.

There is an even worse scenario when you need active treatment and are forced to haggle with the insurer. For example, at a regular check-up in [✂], my consultant discovered that I had a [✂]. She rushed me to a colleague and within ten minutes I knew that I needed surgery pdq. This was offered for the next day so I had to phone Axa from the hospital and then face a prolonged inquisition about which surgeon and anaesthetist would be used and whether Axa would fund their fees in full. It was upsetting and humiliating; and there were ghastly consequences resulting from the fact that I had paid for my regular check-up myself (£[✂]) then had to pay the [✂] consultant (£[✂]) and then Axa would not accept that I had paid my £[✂] policy

excess and wanted me to pay again! Axa would not give clear or timely answers and the result was five months of correspondence, with my complaint to the FSA being only ten minutes away from being posted when Axa's settlement finally arrived. Axa does **not** make fee-capping absolutely clear in its literature and **omits** to mention it when phoning "to check that you are renewing". In addition, Axa's "schedule of procedures and fees" is only accessible online; does not tell you who is fee-capped; and appears to be set on a nationwide basis with no regard for the higher costs applying in London (where higher premiums are charged). As a Londoner, I face discrimination.

[✂]

I cannot transfer to another insurer either, as my pre-existing condition would not be covered, even for flare-ups. This seems very unfair as my understanding is that those who have medical insurance from an employer do not face exclusions/loss of cover for pre-existing conditions if the company moves to another insurer. Corporate contracts are far more favourable than contracts for individual consumers.

I am sorry to have written at length, but feel very strongly that, as an individual consumer, I am getting a raw deal. In particular, the piggy-in-the-middle situation on finance is very unfair, especially when so many errors are made between insurers and hospitals and the patient is held responsible but has no access to information. A friend in the USA has told me of the "Hold Harmless" ruling, so why is this not being applied in the UK? Equally, why is there no penalty-free portability of cover for individuals who wish to move insurers, as there is in Australia?

I hope your investigation will take my views into account and I look forward to any feedback you may be able to give me, please.