Notes of the LCA *"Meet the Insurers"* meeting held at the King's Fund, Cavendish Square W1 on 21st April 2010 at 18:30

Chairman	Geoffrey Glazer (Chairman of FIPO) Duncan Dymond (Chairman of the London Consultants' Association) Chris Khoo (Deputy Chairman of FIPO)
Speakers	Andrew Lawrence (Managing Director, Tribal) Tom Dehn (Chief Surgical Officer, Aviva) Simon Peck (Head of Provider Audit, AXA-PPP) Steven Pink (Head of Provider Relations, BUPA) David Mezher (Chief Operation Officer, PruHealth) Simon Winnard, (Consultant Relationship Manager, Standard Life) Julian Stainton (Chief Executive, WPA)

Andrew Lawrence (Managing Director, Tribal Group)

- The Clinical Coding and Schedule Development Group (CCSD) developed and maintains a schedule of procedure codes which it licenses to insurers (AXA-PPP, BUPA, Norwich Union/Aviva, PruHealth and Simplyhealth).
- CCSD has no role in pricing.
- Tribal Group produces a consensus, maintains the schedule and manages licensing.
- Requests for new procedure codes are received and circulated to a working group. The website is updated monthly.
- Since the launch of the CCSD website in 2006, there have been 395 amendments to the schedule. Forty requests have been declined.
- Requests may be submitted and tracked on line. Pending requests may be viewed.

Tom Dehn (Chief Surgical Officer, Aviva)

- Private Medical Insurers (PMIs) have been traditionally viewed by the profession like a "hole in the wall" cash machine, exercising no control on who does the work, or on standards.
- The PMI has traditionally recruited the customer and paid the Consultant without control of fees. Aviva distributes £95m in Consultant fees per annum.
- In recent years the NHS has improved access time and plurality of providers. Choose and Book has filled the private hospitals in the Reading area.
- Self payers have all but disappeared.
- Medical and hospital costs are soaring, and cost control is vital to keep the business sustainable.
- The market is now driven by corporate buyers who drive a hard bargain with the PMIs. They demand low costs and seek assurance about the quality of Consultants.
- PMIs should be entitled to request audit/outcome data from Consultants.
- While PMIs should not set clinical guidelines (that is the role of the Colleges, speciality associations etc.), they are entitled to expect Consultants to adhere to current best practice.
- "Clinical freedom" will go. Protocols are safer and patients do better.
- Fraudulent claims account for about 5% of those received by Aviva. A number of these are with the collusion of, or even at the request of, the patient.
- A further 20% can be described as "extreme use of the code book".
- Complicated cases must be discussed with the PMI early.

Simon Peck (Head of Provider Audit, AXA-PPP)

- 80% of AXA-PPP's clients are now corporate.
- Their No.1 complaint is the cost of premiums.
- AXA-PPP's response to this has been to decline to pay excessive charges, to control referral to high-charging Consultants and ultimately to cease dealing with the provider.
- An audit of 650 claims across the UK found a number of examples of material fraud, including up-coding, unbundling and misrepresentation.
- AXA-PPP has referred practitioners to the GMC for performing diagnostic procedures while charging for therapeutic procedures.
- It was only during questioning that any mention was made of the AXA-PPP fixed fee schedule for newly appointed and established consultants.

Steven Pink (Head of Provider Relations, BUPA)

- The PMI's marketplace is an ageing population, living longer.
- Corporate clients exert downward pressure on prices.
- 1000 patients a month tell BUPA that private health insurance is too expensive.
- Claiming customers are declining in almost all health regions.
- Clients demand more transparency of information, the creation of preferred provider groups and open referral.
- While these pressures cannot be avoided, the PMIs must engage with Consultants.
- The demarcation between "private" and "NHS" is becoming blurred.
- BUPA's solution is "multidimensional" including alternative offerings, tailored services, care pathway adoption, on-line processing of claims, "certainty of quality and cost" (my quotes) and "improved customer insight" (a concept that Mr Pink left undefined).

BUPA's vision of the future is that they must

- prove private sector quality is better than the NHS
- measure quality and develop a definition of "good" care
- promote clinical practice guidelines
- gather feedback from patients
- promote care that represents clinical excellence
- promote innovative care that values cost-effectiveness

David Mezher (Chief Operation Officer, PruHealth)

- PMI is a very competitive industry in which affordability is key – cost is the main barrier to purchase.
- PruHealth published billing guidelines a year ago.
- Some billing issues arise due to lack of clarity. These can be labelled as fraud.
- PMIs should not dictate practice guidelines but can assess practice against accepted guidelines and can question deviations.
- PruHealth believe that insurers developing networks for cost or quality reasons should be honest about the drivers and processes involved.
- Hospitals, rather than insurers, are the best analysts of outcome data.
- Patient-reported outcomes, piloted in the NHS, are supported by PruHealth.
- "Case management" by specialist nurses may be (?has been) introduced to ensure care conforms to best practice.
- PruHealth have no plans to introduce a fee schedule, but "clinical freedom" without regard to cost is not marketable.
- "Managed care" is not inevitable if we work together.
- Fraud is uncommon, but is increasing. PruHealth will be robust with offenders

Simon Winnard (Consultant Relationship Manager, Standard Life)

- The PMI is a straightforward business model.
- Consultant fees are 25% of costs, so have an impact on profitability and pricing.
- Standard Life's "full refund" principle does not mean "pay everything".
- Standard Life's approach is to accommodate flexibility in clinical practice, taking subspeciality into account in an attempt not to leave the patient with a shortfall.
- In the event of flagrant overcharging, Standard Life is contracted to settle the account, but in the last resort might derecognise the Consultant.
- "Tariff loading" – adjusting fees in the light of which insurer is paying – is of questionable ethicality.
- Standard Life have encountered some fraud – principally unbundling and "phantom treatment" (billing for treatment not carried out).
- There is currently no contract between Standard Life and Consultants. Standard Life would like this to change.

Julian Stainton (Chief Executive, WPA)

- WPA is not at war with Consultants, unlike some of its competitors
- WPA is not interested in "selling" – it turns down about a third of applicants
- Despite this approach, its business has grown by 50% in the last year, much of it corporate.
- WPA is more interested in value than cost, and reimburses "customary and reasonable" fees, of which it publishes a schedule.
- WPA's view is that PMIs should **not**
  - develop clinical guidelines,
  - demand audit data
  - attempt to establish provider networks
  - restrict free choice of Consultant or place of treatment
  - fix fees for new Consultants
- Case management? "I don't know what it means".
- Fraud? Hospitals are at least as guilty as Consultants. Fraud happens occasionally and WPA pursues it. A solution is almost always reached by discussion.