Member of the public 8

1 November 2012

Dear Sir,

Recently I have undergone surgery to my [✂] which was carried out “privately”, the cost of which was underwritten by a “BUPA Select” policy provided by my employer. There have been one or two issues that have arisen over the months and it has been suggested that I should inform you of these because of the ongoing investigation into the private medical insurance market.

I don’t need to go into the medical detail of the problem but briefly, I was advised to undergo a particular complex surgical procedure which also entailed [✂]. This [✂] procedure was carried out in [✂] with a preliminary [✂] done in [✂]. All has gone very well and I have been seeing the consultant surgeon *as he deemed necessary* for examination and re-dressing of the wounds, x-rays to ensure that the [✂] had healed, consequent plaster replacements, etc. My final consultation was [✂], although I continue to have physio-therapy treatment to strengthen and stretch the muscles and ligaments [✂].

The latest problems with BUPA first arose in [✂] when I received notification that certain accounts would not be paid because I had reached the ceiling of the benefit payable under the terms of my policy. Having kept meticulous records of such payments since my treatment began, I knew this not to be the case so I contacted the BUPA office in [✂] to obtain an explanation. It soon became apparent that someone within the BUPA organisation had wrongly allocated several bills from the hospital which should have been paid in full, not from my out-patient benefit and the matter was satisfactorily resolved within a couple of days. I understand from the hospital that BUPA did then pay these bills in full, although a month late because of the delay while the matter was resolved.

I then returned from my holiday in [✂] to find another letter from BUPA advising me that they would not be paying the latest account from my consultant surgeon because “under the terms of my policy” BUPA does not pay for “monitoring and maintenance of a condition”. I therefore read my policy documents very carefully and could find no such term anywhere so I rang BUPA again to find out more. I was told by a rather aggressive young woman that BUPA is not supposed to fund treatment for “chronic” conditions, it is there to provide treatment at a time and place more convenient to the patient. She did eventually agree, after some argument, that the account from the surgeon would be paid after all but could not, or would not, explain why an account for physiotherapy at the same facility on the same date was being paid without question. If ongoing physiotherapy is not “monitoring and maintenance of a condition”, then to paraphrase Mr Ian Hislop, I am a banana! As an aside, there was no problem with the benefit limit having been reached, they just would not pay the surgeon’s account.

There was also an administrative issue because she told me I had “broken their rules” about obtaining what they describe as a “pre-authorisation number” prior to making arrangements for treatment. I was informed in [✂], just prior to the surgery, that the same number for the surgical procedure itself would be used for all subsequent consultations and/or treatment, provided that they were *directly* linked to that surgery. The BUPA woman told me on the telephone that this was incorrect advice and I should obtain a fresh pre-authorisation number each time I saw the

consultant. Her view was that I should have known this in spite of not having been informed and that I had flagrantly broken their rules; this in spite of the fact they had paid all the submitted accounts for some three months without questioning the pre-authorisation number used. Subsequently, I can only assume that *she* was wrong because a fresh pre-authorisation number was not provided when I asked for it in a letter dated [✂] advising BUPA that a further consultation with my surgeon was to take place in two weeks' time.

There are several matters from this case that are worthy of your investigation having read the Issues Statement on your website:

- BUPA only pay surgeons' and anaesthetists' fees to a scale that was set in 1992 (!) and any difference is down to the patient to pay. That difference was understood in my case and I have no issue with such payments. The issue is that it is unrealistic of BUPA to insist that practitioners' fees should be restricted in that way. They do offer to find a practitioner who does charge within BUPA's rates but in my area, they would be hard pushed to do so and I would not have been prepared to travel considerably for surgery and out-patient treatment with a consultant that is unknown to my GP. That policy also limits the patient's choice of practitioner. Is BUPA using its dominant position in the market to "restrain trade"? Is that not an offence under EU law? I should point out that my consultant told me that there are other providers of medical insurance that do pay practitioners' fees in full.

- BUPA appear to have changed the terms of my policy without informing the policy holder; this is against "natural justice" and to my mind, a possible breach of contract. They also seem possibly to have changed the rules regarding the administration of the policy, again without informing the policyholder.

- The people who administer the payment of accounts are not medically trained and I want to know what qualifies an office clerk to make decisions about whether out-patient treatment after complex orthopaedic surgery is medically necessary or not. BUPA would not answer that question when it was put to them. For them to say that any more than two consultations is "monitoring and maintenance of a condition" is ridiculous. My surgeon's opinion is that if he were to say after the surgery "I'll see you in three months for follow-up", he would be guilty of medical negligence. Are BUPA encouraging this by their actions?

- If BUPA do apply this policy change, unless the patient is prepared to argue the case, he would end up considerably out of pocket in spite of there being sufficient funds remaining in the "benefit pot" to pay the account.

- I note that many medical insurance policies do not cover pre-existing conditions. That severely restricts patient choice and there is nothing to prevent an insurer, having paid out for treatment for a specific medical condition to the benefit limit in any policy year, from not covering that same condition should it re-occur in a following year. The patient may then have difficulty in obtaining suitable insurance cover in the future which then puts private medical insurance into the same category as pet and travel insurance and we all know what a potential minefield that has become.

I trust you will bear these comments in mind when deliberating.