

Private medical insurance

Andy Couchman

This is not an easy time for private medical insurance (PMI). Sales remain flat (OK the personal market continues to decline and the company paid market is not exactly thriving either). Costs remain an issue, the CMA (Competition and Markets Authority - the whizzy new name for what we used to know as the Competition Commission) has only just issued its final remedies to sort the private healthcare market, M&A is big business, commission has become an issue and all this against a background of a still painfully slow economic recovery and an NHS that is under ever-closer scrutiny.

Despite all this, industry leaders are not as downbeat as you might have expected. WPA's Adrian Humphreys for example described himself as: "Horribly optimistic". He also applauded the industry for tackling the cost issue and went on to give an overview of some of the trends:

"Thank God someone's woken up and smelt the coffee. Eventually if PMI premiums rise at 5% a year and inflation is at 2%, it becomes unaffordable.

But there's a massive wave about to hit us. People are retiring now who have only ever known having PMI during their whole career. It's a golden period because they are so much fitter going into retirement than earlier generations. They are also quite savvy. So we need to go in for products like Active Life.

For small corporates you only need to talk to them about North Staffordshire. Realism is starting to come in and firms are drifting back into PMI. For them, an ideal product may cover diagnosis plus minor costs, leaving the big issues to the NHS. I'm very optimistic about small corporates – a market that was up 14% for us last year.

On major corporates, I'm utterly bemused by what's going on. There's a mix of inertia, lots of cash floating around but people worried about their jobs. The analogy is people not moving house but building extensions on their current one. We're seeing tiered healthcare starting to take off. Firms want to do more for more people, but at less cost. The demise of the DB [defined benefit] pension scheme is also a trigger. New recruits go into a defined contribution scheme now so that [philosophy] has become acceptable. But the P11D hit is an issue.

A lot of schemes grew last year in terms of number of people, but without premiums going up.

There is also almost a complete stop of healthcare trusts and instead employers are going the corporate deductible route, which is so much easier."

I'll start though with a comment made by ISMI's Andrew Tripp that traditional PMI is 'bust'. Andrew's background as a broker and past chairman of AMII (the recently renamed but same initialled Association of Medical Insurers and Intermediaries) gives him a better understanding of the market than most and his new organisation is opening up new debates – even if he and I have disagreed on how good and/or innovative some of his new ideas are (or were at initial launch). But

he also is promoting his ideas about how PMI should change, so what do others think? Is Andrew right?

Michael Brown of Portsoken Consulting works with Andrew and used to run one of the UK's most successful employee benefits consultancies so is well familiar with the arguments:

"Is PMI 'bust' for most? Not totally but it is most certainly in decline. The whole open referral debacle has added confusion to the market. Only niche intermediaries seem to have an interest in selling it. Yes, there has to be control over escalating costs but open referral is not the answer in itself. As I have said on many occasions there needs to be two products priced accordingly to simplify matters. With the apparent continuing decline in corporate sponsored plans there should be growth in the individual sector but there seems not to be. That says to me that individuals are simply going without at a time when the NHS is stretched and will remain so for the foreseeable future."

PruHealth is another innovative office and its Dave Priestley agrees that better solutions are needed:

"There is no doubt that traditional PMI has had its day. These products have become outdated and commoditised and are less relevant than ever for today's health consumers. However, health and wellness remains right at the top of people's personal agendas and what's needed is a new kind of lifestyle health insurance which not only provides access to high quality clinical care, but also supports people to live a healthy lifestyle in a way that offers tangible additional value every day."

But what of the 'traditional' players? The market remains dominated by Bupa and AXA PPP and AXA PPP healthcare's intermediary distribution director Paul Moulton believes the model itself is not broken:

"No – providers appreciate the importance of cost to individuals securing healthcare cover. With this in mind, at AXA PPP we offer a modular approach to medical insurance enabling new members to build their cover to suit their healthcare needs and budgets. Alongside this, to help people make savings on their premiums we offer no-claims discounts and a range of voluntary excesses as well as 'six-week' policies (for members to go private straightaway when the NHS cannot treat them in under six weeks). Adding this up, a 40 year-old can combine our six week option with a £100 excess to secure our modular plan for less than £8 a week."

And Bupa Health Funding MD Dr Damien Marmion sees the issue in a wider context too:

"For too long the cost of private healthcare has been rising to unsustainable levels, in large part because of a lack of competition and efficiency in the private hospital market and among consultants in private practice. This is why Bupa has consistently welcomed the Competition Commission/Competition and Markets Authority's investigation. We will pass on any money saved from increased competition amongst hospital providers to our customers."

Howard Hughes of Simplyhealth agrees:

"No, however private medical insurance is a mature market. The recession has meant that the market has decreased in recent years but this is due to economic downturn rather than a decline in the attractiveness of the product. We know from our market research that one of

the reasons customers give up this important cover is often down to cost. At Simplyhealth we have responded to customer needs by providing product flexibility.

Medical inflation is continuing to put pressure on premiums. Simply Personal Health for the consumer and Simply Employee Health in the corporate market are both modular plans offering benefit and price flexibility. Both enable customers to have greater choice over their cover and premium.”

Exeter Family Friendly is one of the few providers with feet in both the PMI and long term protection camps, so CEO Andy Chapman’s views are significant:

“There’s no hiding from the fact that there are some serious challenges that the PMI market needs to face up to and overcome.

We’re all living longer and living for longer periods in bad health. At the same time, medical advances mean that more illnesses, conditions and injuries can be solved or managed by medical intervention. But against this backdrop, the role of the NHS is changing. The reality is that without massive additional investment into the health service, its role will be increasingly difficult to achieve. In years to come, we are likely to see a health service that is almost exclusively designed to deal with acute and life threatening problems with anything less serious being ‘out of scope’.

So, where does that leave our industry? Yes, there is a real need to tackle the issue of premium inflation, which has overpriced PMI for many consumers. But, I would also like to think that the changing face of the NHS creates an opportunity for us to provide a crucial and viable service, for a much larger potential market than we do already.

This opportunity will, as is often the case, be best served by those insurers who have the desire to innovate and are nimble enough to move with changes in the NHS as and when they occur. It’s not going to be good enough to develop products and services in the usual inflexible way, all delivered at a snail’s pace.”

For a final word on this issue, let’s go to Regency Health’s Brian Walters for a broker perspective:

“If you consider the take-up of PMI in the general population, it always has been. Considering the broader economic climate the individual PMI market has been remarkably resilient. Although only a small percentage of the population have self-paid PMI, those that have it tend to really value it.”

But PMI does not sit in isolation. It is inextricably linked with the NHS and what happens there affects PMI demand and has done so for more than 65 years now. How does Dave Priestley view the NHS?

“The NHS will continue to be held in very high regard both by the UK public and nations all over the world. However, there is no doubt that the funding of the NHS in its current form is unsustainable.

Ongoing reforms will continue to put pressure on services – irrespective of which party is in government – and the opportunity for the private sector will continue to expand. The lines between public and private will continue to get increasingly blurred over time and private provision will become more accepted as a model.”

Michael Brown is a realist too:

“The NHS is not bust but it is struggling and will continue to do so for the foreseeable future. Continual Government interference in the operating model and burdening the service with growing bureaucracy and, continuous structural change is not going to help stop the rot. The time has come when the NHS should be run by medical professionals rather than professional managers. Little will have changed in five years’ time other than perhaps another structural change brought about by Government of a different political persuasion.”

Paul Moulton sees the NHS under increasing pressure though:

“Survey findings from finance directors working in the health and social care sectors, published in The King’s Fund’s tenth health and social care system monitoring report earlier this year suggest that financial pressures on the NHS are increasing. People’s demand for healthcare services will continue to add pressure on the NHS too and inevitably the squeeze on the Service looks likely to continue.”

It is not just the NHS that faces huge cost pressures. For as long as anyone can remember, the PMI model says premiums will rise by inflation times a factor every year. That hurts whether you are a finance director or an individual struggling to pay premiums from your pension income.

We need to be careful though, because claims costs have moderated recently – and it’s not just because of new initiatives insurers have been adopting. The feared push by GPs keen to get patients out of being funded by the NHS and towards private care has also yet to materialize, according to Adrian Humphreys:

“Claims went up a year to 18 months ago but otherwise have gone up by 4-7% consistently. GPs are not really pushing patients towards the private sector – yet.”

One high profile way some in the industry have sought to control costs has been through open referrals.

I always think that phrase is like the ‘any occupation’ definition in income protection – it ‘sounds’ like giving you more but actually means imposing limits. So, is open referral the way to go – I asked Brian Walters for a broker view first:

“Open referral is a cost-containment option like any other. Provided the client understands that they’re sacrificing an element of cover for a premium saving, I can’t see any grounds for objection. The idea of an ‘open referral’ makes sense once you understand the concept but ‘directional care’ is a better term to describe open referral-type products.”

Dave Priestley believes the key is being open about what it means:

“Questions remain over the ability of insurers to select appropriate referral routes given the lack of availability of quality and outcome data. Let’s call a spade a spade... open referral is a completely reasonable approach to achieve lower costs, but it is at the expense of the customer experience and if we are to avoid further negative media coverage for PMI, we need to be up front with our customers about what they are buying. “

Simplyhealth was an early adopter through one of the insurers it took over, although the open referral tag is one that has come along a lot later. Not surprisingly Howard Hughes prefers to use another name:

“We believe in providing our customers with cost effective solutions and choice. As such, some of our customers opt to use a wide choice of hospital providers, while others choose to be directed to a smaller network of hospital providers.

Instead of open referral we use the term directional care. We believe it is important to provide a range of choices for intermediaries and to provide the solution that best meets customers' needs. We use directional and non-directional solutions to provide a good range of health plans and premiums that meet the needs of all of our customers.

Directional care helps to keep premiums affordable, reduces shortfalls and supports customer experience. In turn it supports the market by helping to ensure that private medical insurance is accessible to more people.”

Howard highlights one of the misunderstandings about open referral. So often it is criticised for taking away choice but, the way most insurers operate it, it is actually a choice of whether to go this route or not. The danger though is that closed referral – if I may call it that – could become ghettoised if most people go for the cheaper option. Paul Moulton makes that point well too:

“Through ‘open referral’, insurers secure access for their members to specialists for investigation and treatment without the need for a GP-named referral.

Open referral is an option for all our members. For corporate clients this enables them to secure treatment for their employees with the reassurance that healthcare provider fees will be paid in full. Our specialist team, using information provided by members and their GPs, apply their knowledge of specialists' clinical practice to identify and offer members an appointment with a suitable specialist (or choice of specialists) close to their preferred location – be it nearer to home or to work. Uniquely we'll even arrange and book their initial appointment if they wish, to help relieve the burden at what can be a worrying time for them.

Open referral is a significant industry development and ultimately we do not feel it's a misleading name for this approach.”

Dr Damien Marmion also gives short shrift to any criticisms of the name:

“Open referral gives customers a greater choice of consultants. The name is not misleading to customers – Bupa gives customers a genuine choice.”

Of course, open referral is not the only way insurers seek to reduce costs. Years ago, reinsurers promoted the major medex concept. Today we tend to call them hospital treatment or surgery plans but the concept remains the same – insurers pay for defined procedures and pay a fixed sum that the customer can spend more or less how they see fit. Refinements include covering some non-surgical treatments (e.g. for cancer) and providing help, especially in buying care. Westfield has chosen this route to enter the PMI space (by acquiring PatientChoice) and other insurers also offer products, but it remains a minority choice. ISMI is one such provider and Michael Brown sees it as part of a wider innovation agenda:

“This is one of a number of options available. Further innovation in the insurance market is needed. Simplicity has to be the key and the products developed have to be easily understood by the buying public. There is much to be said for the providers of care to work in close harmony with insurers and providers. Much occurs behind the scenes which is to be applauded. Perhaps the time has come for the partnership to become very much more visible to the buyer.”

April UK’s new inSpire plan is an example of such partnerships. Back to hospital treatment plans though and Brian Walters sees such plans having only limited appeal:

“These products may gain traction as the cost of traditional PMI rises but the lack of comprehensive cancer cover will limit their appeal.”

So far we have looked largely internally at PMI but, hovering around for what seems like forever, has been the investigation of private healthcare undertaken by the Competition Commission (now the Competition and Markets Authority). In April it published its final report and remedies, which essentially asked HCA International to sell one or two of its London hospitals and for hospitals to stop trying to bribe doctors to use only their facilities (OK, I paraphrase...). To the surprise of some, the investigation largely focused on the supply side and left insurers alone (much to the chagrin of some hospital groups). You can read all about what the CMA actually said (rather than what people think it said or would like it to have said) here: www.gov.uk/cma-cases/private-healthcare-investigation.

Andy Chapman sets the scene from a PMI perspective:

“For any market to deliver great value, products and service to their customers there are a number of essential elements. Fair and true competition and a focus on doing the right things by customers are just two, but two of the most important.

Taking the second point for example, there are a number of practices that have evolved in the market over the years, which could raise genuine questions about whether healthcare providers and hospital groups have the best interest of their customers in mind, especially when it comes to price.

For example, the Competition Commission has just recommended outlawing the practice of consultants being incentivised to refer their patients to certain hospital groups and facilities. This practice is simply wrong and begs the question why it hasn’t been addressed before. The only factors that should influence this decision ought to be based on what is best for the patient, not the bottom line of the hospital group or the consultant themselves.

But, as I write, it seems that some of the early recommendations have been removed or softened, with the major focus of any reforms being to encourage greater competition between healthcare providers in Central London.”

AXA PPP was one of those who supported the investigation in the first place:

“To ensure its members get the best possible healthcare, we have long called for reform of the provision of healthcare services by private hospitals and consultants.

The current situation has led to excessive concentration of hospital ownership, particularly in London, which has resulted in inadequate competition. Inappropriate incentives have also

been given by hospital operators to consultants to encourage them to direct business their way and/or undertake unnecessary tests or treatments. This is clearly against the interests of patients.

Change is long overdue. We have worked closely with the authority to ensure that it has detailed evidence to support its decision to order the divestment of hospitals where concentration of ownership adversely affects competition. We especially welcome the banning of consultant incentives that encourage some specialists to refer their patients to particular facilities.

We also welcome the Authority's findings that private medical insurers are working in the interest of their customers to make the market more competitive and the cost of healthcare affordable.

The Authority's call for healthcare providers to make available better information on the quality of their services and clinical outcomes is also to be applauded. Hospitals and consultants have kept patients in the dark for too long and it is essential that they are given the necessary facts to make informed choices.

The findings of the Authority are the result of a long and extensive investigation taking evidence from across the private healthcare sector. It is now time to drive through much needed reforms to ensure that high quality private health provision is both affordable and sustainable."

Howard Hughes sees benefits for customers emerging from the investigation:

"We believe the findings, when implemented, will ultimately benefit the market and create a private healthcare landscape that is fairer for all.

For us the most important outcome is around transparency of information, allowing patients to make informed choices about their care. This is an area we have been passionate about as an organisation for a long time and a measure that is far overdue. We're also pleased private medical insurers will have a collaborative role to play to aid and shape this flow of information. We have already begun engaging with the relevant organisations that will collate and publish consultant and hospital outcomes.

We will continue to work with and support the hospitals impacted by decisions made by the CMA, and will welcome new entrants into the market. We feel that the changes put forward by the CMA have the potential to reinvigorate the market and act as a catalyst for innovation and growth. We are hopeful that the market seizes the opportunity to explore other models of care and service delivery."

Dr Damien Marmion agrees:

"The final report had some cautious but positive steps in the right direction for customers and patients. The sale of key HCA London hospitals will help to increase competition and will have a positive impact on customers in central London. The sector needs to work together and to go further to revive the market to drive better value for customers and address significant customer detriment, particularly outside central London. This is the only way to achieve a sustainable long term future for the sector and deliver improved value and quality to many more people."

Another external driver is distribution. Traditionally, PMI sales have been driven by large insurer salesforces and a small but expert specialist broker system (many of who are ex company people). But IFAs (independent financial advisers) have always dabbled in PMI too and some held out the hope that the FSA's Retail Distribution Review (RDR) would see more looking to PMI as part of their business model. Has it happened? I asked Andy Chapman and Dave Priestley. First, Andy:

"As an insurer that deals with only protection and healthcare advisers, our experience is that whilst essentially there is a strong link between the two types of product, the two sets of advisers are entirely separate.

We have tried to tackle the status quo by increasing the opportunities for advisers of all backgrounds to increase their knowledge and confidence in the PMI market, but so far our efforts haven't really met demand of any note.

The feedback that we have encountered is that most advisers are happy to pass on leads to a chosen PMI specialist, rather than advise upon the product themselves.

I can understand this in a sense - some PMI policies are so complex they really need a dedicated expert to decipher and disseminate benefits to their clients, let alone choose the right one.

Ultimately, I see the separation of the adviser market mainly as a consequence of many insurers addiction to complexity. If all could take a simpler, more straightforward approach, PMI might be a more accessible product for all advisers. "

...and Dave felt:

"There is no question that many IFAs who have not previously considered PMI see an opportunity in this market now. There are many common sense reasons for this. Consumers look for advice which covers the entire health spectrum of needs and do not work in product silos. It's perfectly logical to extend a fact find around lifestyle and protection into lifestyle and health. They are completely intertwined. There is already rapid growth in lifestyle health insurance sales in the IFA market and those IFAs who grasp this opportunity quickly and invest stand to benefit to a significant degree."

There is a 'third way' on broker distribution though, as Adrian Humphreys explains:

"The way to run brokers is to have very small numbers. Relationships with our brokers are fantastic and our user group approach [facilitated two way feedback workshops] has been so powerful. But there has been no movement of switching to fees – it's just a step too far [for many brokers]."

Indeed, neither flat rate commission nor switching to fees (other than for corporates) has gained much traction – at least not yet. The existing model is just too established and the fear of moving to a new model is just too great.

I have been selective in looking at some of the big issues, but they are not the only ones. So I also asked our contributors for their views on the issues facing the sector. First, Dr Damien Marmion and for him the balance between cost and quality is key:

“The key issue for consumers is the value for money and quality of care they get. Quality is not increasing at the same rate as prices and people can make the judgement that high cost is high quality. This is not always true and many studies in healthcare have shown that high quality of care can be at a low cost. Hence when protecting the workforce it is vital to find out which is the best solution and Bupa’s Open Referral is just that kind of service which pioneered this trend in PMI.”

Paul Moulton understandably focuses on the corporate space in his response:

“The implications of the new Health and Work Service and occupational health tax exemption will be of particular interest to organisations seeking to manage longer term sickness absence more effectively.

For smaller organisations in particular, the Health and Work Service should be a benefit, giving them free access to 'light touch' OH advice. Larger employers, however, might find the Service adds a layer of confusion or complexity to the management of long term absence they may already have in place.

The Government’s decision to remove fiscal disincentives – through OH tax exemption – when employers wish to fund treatment to get longer-term absent employees back to work is to be welcomed. We believe the move should benefit not only employers and their employees but also the NHS and state benefit systems and society more generally. We look forward to publication of the Treasury Regulations that will form the basis for implementation of the exemption so we can better understand how it will support employers and employees in practice.

Again, in the corporate arena, there are future opportunities and challenges associated with the changing nature of ill health and the ageing population, whereby there are possibilities for PMI to further integrate with preventative interventions and/or disease management in the delivery of an effective employee health and wellbeing strategy.”

Dave Priestley sees issues around distribution as another focus:

“Consolidation of intermediary distribution continues at a rapid pace. This is completely understandable given the market economics and business models adopted by many intermediaries. The price and commission led strategies of the last 15 years have resulted in smaller intermediaries being squeezed out. The long term success of the health insurance market depends on customers – especially those who don’t claim - deriving benefits from their products on a regular basis and electing to renew their policies for many years. This requires more product and value led advice which in turn will support better customer satisfaction and attraction and retention of more healthy customers, allowing premiums to be kept at an affordable level.”

Interestingly, none of our contributors mentioned commission. This became an issue, particularly following a very good piece for *Health Insurance Daily* by my colleague Tony Levene on 8 April. You can read the full piece here <https://www.healthinsurancedaily.com/health-insurance/product-area/pmi/article439760.ece>.

It essentially points out that the market has a two tier commission system – one rate for ‘conventional’ business and another (higher) rate where business comes through a lead. Such leads are far from perfect (the same lead can be sold many times over for example) but they do at least

encourage real growth. But is it right to reward such business and, if not, might that lead to a further contraction and greater ultimate consumer detriment. It's not an easy issue to answer and frankly, I think the debate is nearer its beginning rather than its end.

My final question was to ask our contributors where they thought PMI would be in five years' time. Howard Hughes sees PMI as remaining a pretty robust market:

"PMI is resilient, and as the UK economy starts on its road to recovery the employer market may well see renewed growth. It may be that more modular plans are developed where individuals can select which cover they would like, allowing for private medical insurance to remain affordable."

Andy Chapman highlights where PMI will sit with regard to its bigger brother but has warning too:

"More in tune with the NHS, reflecting and complimenting care with relevant and simple modular cover. To be successful and grow the market, we have to find a way to strike a balance, a way to deliver policies at an affordable price without compromising the experience for customers at claim."

"In the past, insurers have been guilty of doing anything to reduce premiums without thinking through the consequences; which are an inevitable backlash and loss of faith in PMI when products fail to deliver at claim. We can't make this mistake again."

Paul Moulton sees new ideas emerging:

"Going forward, employers' strategies for delivering occupational health and medical benefits provision arising from the (aforementioned) Health and Work Service and occupational health tax exemption measures might be particularly relevant in terms of supporting employees who traditionally have not had access to benefits such as private medical and income protection cover."

"With regard to the individual and group PMI market, providers will continue to innovate to ensure that health cover remains valued by members. Sustainability, therefore, will continue to be a key focus and providers will need to continue to explore effective treatment pathways for a range of health issues which manage cost but continue to deliver clinically appropriate treatment and excellent member care"

As does Dave Priestley:

"Traditional PMI addresses the health issues of yesterday. The future is lifestyle health insurance."

Brain Walters is not so optimistic though. He sees PMI:

"Possibly struggling. Compounded 10% (or more) year-on-year increases are only sustainable for so long, so something will have to give."

Let's leave the last word to the market leader and Dr Damien Marmion remains positive:

“There will be a time lag between the CMA’s remedies and effects. We don’t know how long this will take but we look forward to passing the benefits on to our customers once the remedies have been implemented.

“Our goal is to attract millions more people into private healthcare to ensure that they can benefit from the services we offer. It is therefore absolutely in line with our mission to keep costs down and make health insurance more attractive to more people.”

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