TRAVEL HEALTH INSURANCE PRODUCTS
ISSUES PAPER

A document prepared by the
Canadian Council of Insurance Regulators (CCIR)
Travel Insurance Working Group

This document reflects the work of regulators who are members of CCIR and is intended to generate discussion. The views expressed should not be considered as legal opinions.

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EXECUTIVE SUMMARY

This Issues Paper (the "Paper") outlines the preliminary understanding of the Canadian Council of Insurance Regulators ("CCIR") in respect to the Canadian Travel Health Insurance marketplace.

At a time when the fair treatment of consumers is at the heart of international concerns, CCIR believes that it is essential to assess potential issues related to Travel Health Insurance ("THI") and consider options to enhance consumers' protection and confidence. CCIR feels that, for this particular product, there is a potential for misalignment between consumer expectations and industry practices based on identifiable knowledge and expectation gaps.

This Paper considers each of these gaps in a holistic manner, based on the entire lifecycle of the THI product. To that effect, the Paper reviews the design and market conduct practices of travel health insurers in Canada. Specifically it addresses potential issues with product design, marketing and sales, involvement of third party service providers, claims management, complaints, education and data collection.

Specific questions to stakeholders are included in the Paper.[1] However CCIR invites stakeholders to provide any relevant feedback that could assist the regulators to address issues and improve the fair treatment of consumers. Such consultation with industry and other stakeholders should yield results that should ultimately be beneficial for consumers and industry alike.

[1] A list of these questions is attached as Schedule 1 to this Paper.

1- CANADIAN COUNCIL OF INSURANCE REGULATORS

CCIR is an inter-jurisdictional association of provincial, territorial and federal insurance regulators. The provincial and territorial regulators are responsible for market conduct regulation and legislative compliance of insurers authorized in their province or territory. They may also have responsibility for the solvency of insurers incorporated in their jurisdictions.

One of the major goals of CCIR is to facilitate harmonization of insurance regulation across Canada to benefit both consumers and the insurance industry. Working towards a harmonized approach promotes efficiencies and cost savings while providing consistent protection to consumers across Canada.

It is recognized that individual jurisdictions may need to accommodate any local or regional issues in implementation.

2- INTRODUCTION

As provincial health insurance plans reimburse only a very small portion of medical expenses incurred outside of Canada[2], Canadians rely upon travel insurance to protect themselves from financial hardship when travelling outside the geographical boundary of coverage of other insurance they hold (e.g. provincial health insurance plans).

Canadian travelers get travel insurance because they wish to be covered for medical care received as a result of an accident or illness that occurs outside of their home province. Consumers who purchase travel insurance believe that their coverage will provide them with complete protection from hefty bills resulting from medical treatment. However, this is not always the case due to, for example, pre-existing conditions, length of travel, or ineligibility. This can lead to adverse financial consequences when, for example, consumers end up being unable to cover significant medical bills without the benefit of insurance or when their claims are denied as a result of a misunderstanding on their coverage. When publicised by the media, such events can be detrimental to consumer confidence in the role of travel insurance and the reputation of insurers and industry.

In response to growing concerns over public confidence in the market and the manner in which THI is manufactured and distributed, CCIR formed a working group on travel insurance at its fall 2014 meeting (the "Working Group").

2.1 Travel Insurance Working Group

The Working Group is composed of representatives from the CCIR and from the Canadian Insurance Services Regulatory Organizations ("CISRO"). The Working Group's mandate is to improve consumer's confidence in the THI market and to promote harmonization in regulatory approaches to travel insurance in Canada.

[2] Provincial government health plans generally cover only the medical care provided within the geographical area of the province. However, there is an interprovincial agreement that allows a resident of Canada to receive services in a hospital of another province upon presentation of the health insurance card without having to pay for them.

At the Fall 2014 CCIR meeting, the Working Group was tasked with identifying practices that are causing harm, or have the potential to cause harm to the public, and to develop recommendations to address them in order to prevent loss of consumer confidence. In achieving this mandate, the Working Group was also asked to consult with industry stakeholders where possible.

The work of the Working Group is in alignment with CCIR's strategic priorities of identifying common emerging issues (fact gathering), and engaging stakeholders and policy makers so that the right information is in the hands of those in charge of making policy decisions in a timely manner. It is also in alignment with CCIR's risk-based approach to regulation.

The Working Group undertook a thorough review of the Canadian THI market in order to identify and better understand the issues. The Working Group conducted a survey in 2015 and liaised with various industry stakeholders such as:

- The Canadian Life and Health Insurance Association;
- The Travel Health Insurance Association;
- The Canadian Association of Financial Institutions in Insurance;
- The General Insurance Ombudservice; and
- The Ombudservice for Life and Health Insurance.

In addition, the Working Group called for public submissions in February 2015 and received 27 submissions. Finally, the Working Group considered disclosure documents, policies and other material made available and obtained through the course of the regulatory activities of its members.

2.2 The Purpose of this Issues Paper

This Paper aims to set out the context and situation of the THI market as CCIR believes it currently exists. It reflects what the Working Group has learned from the 2015 survey and other findings based on the above-mentioned materials. It is intended to stimulate discussion, launch a process of consultation as well as to educate and build a common understanding of the topics and issues for both regulators and stakeholders.

CCIR seeks to engage stakeholders (from both the industry and the public), on the accuracy of its findings and to obtain their views on how best to achieve the fair treatment of customers in the THI market. More specifically, stakeholders are asked to provide their input on:

- Whether CCIR's understanding of the topic and issues as presented is accurate;
- Whether all significant issues have been identified; and
- Whether the proper questions have been asked to mitigate the issues and gaps identified in this Paper.

Some of the stakeholders identified above have already presented to the Working Group some initiatives they have undertaken or plan to undertake to enhance consumers

experience with THI. CCIR acknowledges the engagement of the industry and will continue to work with these stakeholders in light of the issues raised in this Paper.

Throughout this Paper, THI means any product containing health-related coverage complementary to provincial or territorial health insurance plans only. It excludes products sold to visitors, students living temporarily in Canada and expatriates. It also excludes insurance products sold to Canadians travelling within Canada and employer group insurance products where the insurer provided administrative services plans ("ASO") only.

2.3 Fair Treatment of Customers

Fair treatment of consumers is increasingly becoming the central focus of international bodies' standards and principles. Both international standards setters and governments are raising the bar in market conduct regulation by emphasizing the importance of treating consumers fairly. Over the past years, the insurance industry has begun to adapt its practices to these new or improved requirements, the most important being the Insurance Core Principles ("ICPs") 18[3] and 19[4] of the International Association of Insurance Supervisors ("IAIS").[5]

Although it is not the aim of this Paper to examine at length the compliance of the THI industry to the ICPs, it is important to summarize some of their key aspects in order for the Paper to achieve its purpose.

ICP 19, which relates to conduct of business, established the necessity for the "supervisor to set requirements for the conduct of the business of insurance to ensure that customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied".

The standards found under ICP 19 are aimed at helping to strengthen public trust and consumer confidence in the insurance sector. The IAIS does not prescribe a specific approach or expectation regarding the fair treatment of customers. It does, however, suggest that insurance supervisors and insurers should focus on achieving outcomes such as the following:

- Developing and marketing products in a way that pays due regard to the interests of customers;
- Providing customers with clear information before, during and after the point of sale;
- Reducing the risk of sales which are not appropriate to customers' needs;
- Ensuring that any advice given is of a high quality;

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[3] "*ICP 18 Intermediaries*
The supervisor sets and enforces requirements for the conduct of insurance intermediaries, to ensure that they conduct business in a professional and transparent manner." www.iaisweb.org

[4] "*ICP 19 Conduct of Business*
The supervisor sets requirements for the conduct of the business of insurance to ensure customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied" www.iaisweb.org

[5] "*IAIS is the international standard setting body responsible for developing principles, standards and other supporting material for the supervision of the insurance sector and assisting in their implementation*." http://www.iaisweb.org/page/about-the-iais. *ICPs provide a globally accepted framework for the supervision of the insurance sector.*

- Dealing with customer complaints and disputes in a fair manner;
- Protecting the privacy of information obtained from customers; and
- Managing the reasonable expectations of customers.

ICP 19 also states that the fair treatment of customers should form an integral part of an insurer's business culture and be promoted by its management structure and embedded in all of its key functions (strategy, decision making, internal controls, etc.).

More importantly, the IAIS expects that practices and outcomes should take into account the nature of the customer and the type of insurance sold.

3- THE TRAVEL HEALTH INSURANCE SURVEY

CCIR Members conducted a survey in 2015 to obtain information from regulated insurers about THI products sold in Canada. The survey was sent to 241 insurers and was designed to gather information on their 10 main travel insurance products for the 2014 calendar year.

The Working Group encountered challenges in analyzing the data from the survey. It appears that the data requested is not systematically collected and/or monitored by the industry. As a consequence, the Working Group noticed that some of the requested data was missing and that there were inconsistencies in some of the information provided. This prevented the Working Group from conducting the in-depth analysis it initially wanted to achieve. Still, significant parts of the survey were found to be reliable and this allowed the Working Group to make notable observations.

In total, 33 insurers and financial groups[6] responded that they offered THI products to Canadians in 2014. Most of them (64 percent) offered their products in all of the Canadian provinces and territories. The survey identifiedthat there were 614 individual and 170 group THI products on the Canadian market in 2014. It is important to note, however, that the survey was focused only on the 10 main products listed by each insurer and that the findings of the Working Group focused solely on 145 individual insurance and 101 group insurance THI products which generated about $839 million in gross written premiums (net of voids) in 2014.

The survey also indicated that more than 12 million individual policies and group insurance certificates were issued for these main products during that period and each policy could grant coverage to one or more persons (e.g., insured's partner or children).

The survey results also illustrated that these products were offered to Canadians through three main distribution channels. In no order, they were:

- Credit cards;
- Licensed agents; and
- Travel agents / agencies / other exempt sellers (jurisdictions without restricted certificates).

[6] See the list under Schedule 2.

The survey indicated that claims were made on about 2 percent of the total number of policies/certificates issued with approximately 7 percent of those claims denied and approximately 50 percent of the total premiums paid out in benefits. The survey did not provide reliable data on the number of policies voided. The denial rate was approximately the same for both, individual and group coverage, the leading reason for claim denial being that there was "no coverage"; however, the survey results did not provide sufficient details to allow the Working Group to identify specific situations or circumstances to explain denials based on this motive. The second reason for claim denial was "exclusions", either for pre-existing conditions or other exclusions.

The Working Group observed that there were twice as many group insurance certificates issued compared to individual insurance policies. However, keeping everything in proportion, there were almost twice as many claims submitted in individual insurance compared to group insurance. The survey results also suggest that complaints represent less than 0.5 percent of all claims submitted.

Based solely on these results and despite the lack of a complete in-depth analysis of the THI market, the Working Group could have concluded that there is no need for immediate regulatory action to address the issues found within the THI industry.

4- COMMON FEATURES AND PRACTICES IN TRAVEL HEALTH INSURANCE IN CANADA

THI provides protection for unexpected medical emergencies that may occur while travelling. Generally speaking, THI products are designed to cover Canadian residents who are insured under a Canadian Government or Provincial Health Insurance Plan ("CGHIP" or "PHIP") during the entire duration of their insured trip. Coverage granted applies as a supplement to CGHIP and PHIP. The trip must take place outside of the province or territory of the insured's residence, or outside of Canada.

Travel insurance policies are typically a bundle of accident and sickness and property and casualty insurance ("P&C").[7] The common benefits of THI products are emergency hospital and medical costs due to a sudden and unforeseen illness or accidental injury. A majority of these insurance products also cover losses that result from trip cancellation or interruption due to health-related reasons, and might include P&C benefits like loss or damage of personal property during the trip and delayed arrival of personal baggage while on the trip.[8]

There does not seem to be standard THI products. THI products extend from one protection (i.e. trip cancellation) through full comprehensive coverage, they can be offered separately or in bundles and they can provide coverage for one specific trip or multiple trips.

[7] "Property and casualty" insurance is insurance that protects property from damage or loss.
[8] See a detailed list of typical protections in Schedule 3.

5- ISSUES AND GAPS

5.1 Product Design

5.1.1 The Complexity of Travel Health Insurance Products

THI products can be complex for consumers to understand, depending on the nature of the product and the type and situation of the consumer involved. Considered separately, THI protections are not excessively complicated but when offered in bundles they become more complex since they include several types of coverage (medical or non-medical) which are usually subdivided (emergency medical care, hospitalization, ambulance cost etc.).

The Working Group has observed that insurers often combine different coverage in order to create "plans". A single product will often present several plans (basic, general, superior, etc.) to choose from. Also, these plans may be offered under a single-trip plan, a multiple-trip plan or both. In these cases, insurers present modular clauses in the policy or certificate so that it can be adapted to different plans. In addition, each of the coverage may have its own effective date, exclusions, pre-existing medical conditions, etc. Most insurance products present information about at least two insurance plans.

Different plans often target different categories of consumers, based on their age and trip duration. Eligibility conditions and protections included will change according to the consumer's age and trip duration.

The Working Group believes that the complexity of the design of some THI products can be an obstacle to the consumer's ability to fully understand all available options and relevant limitations.

5.1.2 Terminology and Definitions

Although consumers tend to see THI as a homogenous product, the THI market is very diverse and insurers offer a wide range of products to consumers. The Working Group noticed that key terms and conditions used in these products lack standardized definitions and terminology. The vocabulary and definitions seem to vary not only from one insurer to another but also from one product to another offered by the same insurer.

In the course of their supervision activities, the Working Group members noted that the same concepts were sometimes referred to with different expressions/words. They also noted that the same words were used to represent different key concepts. The Working Group members also observed that the meaning given to certain key words, such as "*emergency"*, "*sickness"* or "*treatment*" to name a few, do not always have the same scope and in some cases, the insurance terminology commonly accepted by the industry seems to be misused.

For example, the Working Group has seen the expression "*insured risk"* to describe the events that will generate the benefit under a risk covered by the insurance rather than describing the risk itself.

Navigating the vast array of available THI products and options can be confusing for the uninitiated. The lack of consistency in the use of terminology and the absence of

standardized definitions adds to the confusion. In fact, it makes it hard for consumers or anyone else to compare and understand products. The Working Group believes that this could also compromise the consumer's ability to understand the extent of the coverage of a particular product, thus to make informed decisions.

Questions at Issue – Design of a THI Product

1. What terms or expressions should be defined and standardized in order to allow a better understanding of THI products by consumers, and enable them to more readily compare products and make informed decisions?

2. What other initiatives related to product design could be put in place by the industry to help consumers better understand the extent of the coverage offered and the terms and exclusions, so they can make informed decisions?

3. What type of controls should be put in place at the insurer or other levels in order to ensure that consumers of THI products are treated fairly?

5.1.3 Underwriting of Travel Insurance Products

Underwriting is "the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned." [9]

Under a traditional underwriting process of a life and health insurance product, the applicant answers personal detailed medical questions in his or her application form and the insurer then decides whether it will accept or refuse to cover the risk. Acceptance by the insurer can be subject to specific conditions.

In contrast, THI products are often based on automatic acceptance. In fact, based on the replies to the survey, the Working Group observed that 95 percent of the applications for THI products that were sold in 2014 had been accepted automatically; the applicants may have answered general medical questions in the application form but did not undergo any additional underwriting process beyond that. In such situations, premiums are determined according to the value and duration of the trip and the consumer's age rather than his or her medical condition. The Working Group considers this to be an exceedingly high automatic acceptance rate and is surprised that so few applicants have to undergo medical examinations during the underwriting process.

5.1.3.1 Exclusion, Restriction and Limitation Clauses

The Working Group believes that the high automatic acceptance rate of applications may be due, at least in part, to the existence of exclusion, restriction and limitation clauses, including those pertaining to pre-existing medical conditions, which spare insurers from conducting further medical underwriting at the time of subscription.

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[9] GOUVERNEMENT DU CANADA, TRAVAUX PUBLICS ET SERVICES GOUVERNEMENTAUX CANADA, 2016, *TERMIUM Plus, la banque de données terminologiques et linguistiques du gouvernement du Canada,* un produit du Bureau de la traduction, [Electronic resource], online : <http://www.btb.termiumplus.gc.ca/tpv2alpha/alphara.html?lang=fra&i=1&srchtxt=ressource&index=alt&codom2nd_wet=1 > (Electronic visit : February 18, 2016).

Pre-existing medical conditions are health-related problems that have existed before a consumer applies for insurance. In general, insurers will exclude known pre-existing medical conditions from coverage or charge higher premiums to cover them.

Where exclusions, restriction and limitation clauses, including those related to pre-existing medical conditions, are used rather than a traditional underwriting process, the burden of determining the limits of coverage that apply to the insured lies with the applicant.

This burden is particularly heavy when exclusion for pre-existing medical conditions could be applicable. These exclusions can be particularly difficult for consumers to interpret and understand,[10] given that the health related conditions are often described in medical terms that are not accessible to all. The issues regarding the lack of standardized terms and definitions previously raised can also compound matters further.

The Working Group is concerned that consumers might not be in a position to understand the key conditions and exclusions that may affect their eligibility or suitability to a given product. Often, consumers do not expect that THI products will contain such clauses or simply don't fully understand the scope of such clauses, thus creating expectation and knowledge gaps. Price and speed of getting coverage then become overriding considerations for those consumers.

Speed is sometimes a crucial consideration for the consumer. When consumers make late travel decisions, they do not have time to undergo the whole underwriting process. Choosing a THI product with automatic acceptance allows them to get insurance in a timely-manner. Speed simplifies the consumer's ability to obtain the THI product while placing him or her in a position where he or she might not have the needed and expected coverage.

These underlying factors and the expectations which they create likely contribute to the perception, amongst consumers, that applications are reviewed post-claim[11]. This, in turn, can affect the reputation of the THI industry and the efforts deployed by its stakeholders to continuously improve products and practices.

While the efforts deployed by the THI industry to mitigate this perception is commendable, the Working Group is concerned that the type of information required to understand restrictions, limitations and exclusion clauses might not always be known or available to applicants. It might therefore not be fair to apply such clauses without proper informational or educational material. Even with proper informational and educational material, the Working Group wonders to what extent a consumer having no medical credentials can make an informed decision when purchasing a travel insurance product as the majority of them are currently designed.

[10] Furthermore, the Working Group has observed a new trend: pre-existing condition clauses that apply to people other than the insured. Pre-existing condition clauses may apply to the person hosting the insured during his or her trip. For instance, one insurer mentioned in its disclosure documents that no trip cancellation benefits will be paid if the trip is cancelled because of a medical problem sustained by the host, if this problem was not stable in the year before the trip. That is to say that the insured must be made aware of all medical problems of his or her host in the year that precedes his or her trip.

[11] See section 5.4 for more details.

Questions at Issue – Exclusion, Restriction and Limitation clauses

4. How could the industry improve consumers' awareness about and understanding of exclusion, restriction and limitation clauses, especially pre-existing medical conditions?

5. What changes could be made to the application process to ensure that consumers have sufficient knowledge to have a thorough understanding of exclusions for pre-existing medical conditions as well as to complete an application for THI, thus enhancing consumer confidence in the underwriting process?

5.1.3.2 Suitability

When opting for a product with automatic acceptance, the burden of determining whether a given insurance product is suitable lies with the applicant. This fact does not seem to be clear to some consumers and the acceptance of an application, even though it is automatic, may give a false sense of security among consumers or create unrealistic expectations.

THI products are offered for a very large pool of individuals whose age and medical condition may vary. Certain products with automatic acceptance might not be suitable for someone with a medical history and again, it seems therefore important that consumers be made aware:

- That the insurance product they are being offered does not involve an extended underwriting process on the part of the insurer; and

- That their particular health condition might not be covered and that it would be of benefit to them to turn to an insurance product with less exclusions and which involves going through an extended underwriting process.

Training is an important tool in bridging the gaps and issues found in this Paper. People offering these products, licensed or not, should be trained to recognize the situations mentioned above and act accordingly. At this time, the Working Group notes that exempt sellers do not have training in insurance (except for that provided by the insurer about the exempted product) nor any obligation to know the consumer's needs or to determine the suitability of the product they are offering.

To ensure the fair treatment of consumers, the Working Group believes that a pre-screening/flagging process might be relevant to identify customers who should first speak with a THI expert or undergo a more thorough underwriting process before acquiring a THI product.

Fair treatment of customers involves achieving outcomes such as developing and marketing products in a way that pays due regards to the interests of consumers. Insurers are expected to take into account the interests of different types of consumers when developing insurance products, and thus the Working Group feels that insurers should carry out a diligent review of their THI products in order to ensure that they are

adapted to the consumers for whose needs the product is likely to be suitable, while limiting access by those for whom the product is likely to be inappropriate.[12]

Question at Issue – Suitability

6. How can the industry ensure that consumers are offered THI products that are suitable for their needs?

5.1.3.3 Medical Questionnaires

Applicants must answer complex and technical medical question that are important in the insurer's appraisal of the risk to be underwritten. The absence of clear definitions and standardized terminology mentioned above further compounds the acuteness of the issue of medical questionnaires. One of the common complaints raised by consumers and by industry observers is that they are too complicated even for medical experts to fully understand.

Yet, these medical questions or questionnaires are particularly important for the application process and failure to properly complete them can lead to very serious consequences, such as denial of coverage or voidance.

Any error or omission to disclose a medical condition, whether related or not to a later claim, can lead to claim rejection and policy voidance, even when consumers answer medical questions in good faith and to the best of their knowledge and understanding. Fully understanding the significance and scope of such questionnaires as well as being able to understand the questions themselves is of the utmost importance to consumer protection and the overall client experience.

Furthermore, the review of the survey data has allowed the Working Group to realize that when there was a medical questionnaire to be filled, it was, in few cases, the applicant who was responsible for answering the medical questions on every traveller's behalf. In practice, this can speed up the application process, but since applicants may not be aware of the other travellers' pre-existing conditions, nor that other travellers might wish to add information pertaining to pre-existing conditions, the Working Group is concerned that this way of doing things might alter consumers' confidence in the THI industry.

Question at Issue –Medical Questionnaires

7. How can the use of medical questionnaires by insurers be improved in the context of the underwriting of travel insurance products, in order to ensure fair treatment of customers?

[12] ICP 19.

5.2 Product Marketing and Sales

5.2.1 Disclosure Obligations and Sales

The design of THI products can be extremely complex. Insurers offer a wide variety of protections that can be combined to create plans which may be offered for a single trip or multiple trips.

The Working Group emphasizes again that THI products may contain numerous exclusions and that the burden to understand their scope and significance is left mainly to the consumer. Under such circumstances, it is crucial for consumers to receive clear and comprehensive information on the THI product in a timely manner.

The Working Group expects the information to be provided in a way that is clear, fair and not misleading. The information disclosed should enable customers to understand the characteristics of the product they are buying and help them understand whether and why it meets their requirements. It should allow consumers to fully understand the extent and limits of the coverage they are purchasing.

The Working Group has found that the information provided is not always drafted in plain language and not sufficiently comprehensive, to the point where consumers do not seem to have a full understanding of the THI product. Indeed, the survey indicated that of all claims denied, 21.6 percent in individual insurance and 48.1 percent in group insurance were denied because the claims were “not covered”. Although, this did not represent a significant portion of the amounts claimed,[13] the Working Group considers this ratio to be high. In addition, 30 percent of the claims made with regards to individual THI products were denied because of exclusions (for pre-existing conditions as well as exclusions for other reasons).

This strengthens the Working Group's position that disclosure is an important issue and that coverage and exclusions should be better understood. Documents and timing of disclosure appear to be key issues.

5.2.1.1 THI Documents[14]

Besides having complex designs, THI products target a wide range of consumers of different ages, education and literacy. Therefore, these products would benefit from documentation that would meet the utmost standards of legibility.

The complexity of THI products partly lies in the variety of protections that may be offered in bundles or combined to create plans that may be offered under a single-trip plan, a multiple-trip plan or both. A single product will often present several plans (basic, general, superior, etc.) to choose from. Each plan may have its own characteristics (effective date exclusions, pre-existing medical conditions, etc.) and often target different categories of consumers, based on their age and trip duration (eligibility conditions and protections included will change according to the consumer’s age and trip duration).

[13] Approximately 10 percent of the amounts claimed.

[14] For the purpose of this paper “THI documents” mean any document pertaining to THI products. This includes namely insurance contracts, applications and disclosure documents.

Currently, all these combinations are typically disclosed in legal and technical language, generally within a single insurance contract and in one disclosure document. This practice results in lengthy and illegible documents, where the information is abundant and scattered. The Working Group believes that such complexity in the products can lead to consumers not being as informed as they should be about the product and potentially, in their view, not being treated fairly.

5.2.1.1.1 Length and Complexity

The burden of fully understanding the product, particularly the limits thereof, lies to a large degree with the consumer; hence the importance of keeping the information simple and easily accessible.

We found that THI documents tend to be lengthy and complex. They describe all options and plans available in a single document while often many of the plans/coverage and options disclosed do not apply to the consumer's situation or needs. Because there are so many elements to disclose, the documents get more complicated and voluminous.

Example

Peter and John, two 64 year old retirees, are offered an insurance product where they can choose between single-trip insurance and multiple-trip insurance and from 14 plans and 8 coverages. The options are all described in the same 85 page booklet.

Depending on the package they choose, the conditions change. They must be:

- 60 years old or more for plan *A Superior*;
- Less than 85 for plans *B single-trip* or *C annual-trip comprehensive coverage;*
- Less than 70 for *$150,000 Plan D;*
- Less than 60 for *Plan E medical care only;*
- Etc.

Exclusions also vary:

- For a trip worth less than $15,000, their health condition must have been stable for 3 months before the insurance takes effect;
- For a trip worth $15,000 or more, it must have been stable for 12 months;
- For all Superior and Comprehensive plans:
    - People less than 60 years old must refer to exclusions nº 6 pertaining to pre-existing conditions;
    - People 60 or more who chose plan D+: no pre-existing condition exclusions apply;
    - People 60 or more who chose plan D: refer to exclusions nº 6 pertaining to pre-existing conditions;
    - People 60 or more who chose plans B or C: refer to exclusions nº 7 pertaining to pre-existing conditions;
    - Etc.
- For all Comprehensive plans, there are no pre-existing condition exclusions;
- Etc.

The Working Group observed that ancillary features[15] sometimes added in THI products are also explained within the THI documents. Though, these features may be interesting, they are not part of the THI and contribute to making the THI documents even more cumbersome.

As well, some insurers cross-reference sections in their THI documents. Doing so does not allow consumers to see the true impact of certain clauses. As such, consumers may not realize or easily understand which exclusions apply to their situation or how the application of these exclusions might be modulated depending on the regime which applies to them. Considering the importance of these factors, the Working Group feels that all information pertaining to each plan should be easily found and should not bring confusion between plans.

Example

June is reading documents pertaining to travel insurance she wishes to buy. In the disclosure documents, there are 15 different plans available, which include more or less benefits depending on her age and prior medical condition. In the disclosure documents, she finds:

- The disclosure document has 85 pages;
- Four pre-existing condition exclusion bundles have to be linked to the insurance plan chosen; they are found on pages 57 to 60;
- These exclusion bundles refer to definitions that are on pages 7 and 8;
- Other exclusions are found on pages 49, 57 to 63, 65, 69, 71 and 73.

Often, there is so much information and details scattered throughout the numerous pages of the documents that it makes it rather complicated and laborious for consumers seeking to find and understand relevant information on the product and compare it with others. The Working Group observed that the documents are often too difficult for the average consumer to read and understand.

In disclosure documents, the emphasis should be on the important elements rather than on extra or irrelevant components which may cause consumers to be distracted from the fundamentals or to not fully read the documents. The Working Group stresses that disclosure documents are intended to ensure the consumer has a proper understanding of the coverage, conditions, limitations and exclusions of the product in order to make an informed purchased decision. Current practices do not appear to meet this objective and, as such, do not treat customers fairly.

The Working Group also noted that, some disclosure documents are literal copies of the insurance contract to which information is added. Consequently, these documents tend to be longer than corresponding insurance policies/certificates. The objective of disclosure documents is then hardly reached.

As an example, in Québec, under the distribution without a representative regime (equivalent to incidental selling in other provinces), the Autorité des marchés financiers

[15] For example, the remittance of a gift certificate for another trip if the insured missed at least 70% of his or her insured trip in case it was interrupted because a family member has died.

noted that in 2015, 65 percent of travel insurance disclosure documents (i.e. distribution guides) filed in Québec[16] were more than 30 pages long.

Number of pages per distribution guide	Number of distribution guides	
Between 10 and 19	15%	
Between 20 and 29	20%	
Between 30 and 39	24%	65%
Between 40 and 49	17%	
Between 50 and 99	22%	
100 and over	2%	

The Working Group firmly believes that the length and complexity of THI documents, especially disclosure documents, is a barrier to customer's involvement and understanding. It would be advisable to focus on the quality of disclosure rather than the quantity of disclosure; we must bear in mind that when these documents become too voluminous, customers may be less likely to read the information and even less likely to understand it.

Moreover the Working Group is inclined to believe that effectiveness of disclosure documents would be improved by the introduction of a standardised format for disclosure (such as a product information sheet), which could enable consumers' understanding, aid comparability across competing products and allow for a more informed choice.

5.2.1.1.2 Language

Besides being complex and lengthy, THI contracts are not, as a rule, written in plain language. Rather, they are drafted using legal language and are not easily accessible to the average reader. But the Working Group has seen that applications and disclosure documents also tend to be legalistic and hardly legible. Thus, one of the common complaints heard from consumers is how confusing THI documents are.

The information provided should be clear, fair and not misleading.[17] The Working Group believes that some effort is required to improve the readability of THI documents, especially applications and disclosure documents.

5.2.1.1.3 Quality Control

In the course of their regulatory activities CCIR members have noticed that THI documents contain at times inconsistent or conflicting information. Regulators have found diverging information such as amounts of benefits, duration, nature of coverage, etc. among the documents pertaining to the same THI products.

[16] Some of these guides are also used in jurisdictions other than Québec.
[17] ICP 19 (19.4).

Example

> Richard bought multiple-trip *Travel Health Insurance*. In the disclosure documents the maximum trip length covered is 60 days while the insurance policy states 48 days.

This makes it even harder, if not impossible, for consumers to understand products. This also leads CCIR members to be concerned with the quality controls implemented by insurers over document preparation.

Questions at Issue – Disclosure Documents

8. How could insurers ensure that the information shown in the disclosure documents is limited to that which is essential, and that the format of these documents promotes a quick understanding of the fundamental information?

9. How could the industry improve disclosure documents so that they can be more easily understood by consumers?

5.2.1.2 Timely Disclosure

When buying any insurance product, including THI products, customers should be properly informed. The information provided should enable them to make informed purchase decisions before entering into a contract.[18]

In the context of THI, since products are offered through various channels including in person, online and through exempt sellers, and products themselves are quite complex, the need to ensure appropriate disclosure before the product is sold is all the more important. To make an informed purchase decision, consumers should be able to readily find the main characteristics of a product and fully understand the extent and limits of the coverage to enable their purchase decision.

The Working Group has been made aware of situations where disclosure documents are provided after the insurance has been purchased. As well, it has found that in the case of certain THI products no details of the coverage, exclusions, restrictions and limitations are provided until after the purchase is made.

The Working Group finds that the timing for the provision of information is not always suitable or acceptable. Disclosure documents should be provided upon the expression of interest by the consumer but before the purchase since these documents are intended to provide consumers with the information that will help them make an informed decision. Whereas the information provided after the point of sale, namely the insurance contract, should help them confirm whether or not they have made the right decision.

Questions at Issue – Timely disclosure

10. How can the industry ensure that consumers are informed of the key elements of the THI coverage in a timely manner, before they make a purchase decision?

[18] ICP 19 (19.5).

5.2.2 Distribution Channels

THI is available through several distribution channels as individual or group products. Consumers can get THI through licensed insurance representatives, deposit-taking institutions, travel agents, employee benefits plans, directly from insurers and as a credit card benefit (embedded or not).

According to the survey results, in 2014, THI products were mainly offered through these distribution channels:

- Group insurance was offered through credit cards in 77 percent of cases;
- Individual insurance was offered by :
    - Licensed agents (40 percent); and
    - Travel agents / travel agencies / other exempt sellers (36 percent).

From the survey, the Working Group noted that, keeping everything in proportion, the number of claims submitted with regards to group insurance certificates was half the number of claims presented in individual insurance policies, while there were twice as many group insurance certificates issued compared to individual insurance policies.

This leads the Working Group to conclude that there could be a relationship between the distribution channel mostly used with group THI, that is, “credit card”, and the fact that fewer claims were presented.

The survey did not allow the Working Group to establish a relationship between the distribution channels and the number of policies voided.

5.2.2.1 Credit Card

From the survey replies, the Working Group noted that 41 THI products were offered through credit cards (embedded[19] or not), in 2014. All credit card holders were automatically accepted.

THI products sold with credit cards (embedded or not) target a broad range of consumers of all ages and medical conditions.

Despite the expectations, where the insurance product is embedded in a credit card, full coverage does not necessarily apply to all consumers. Indeed, the extent of the coverage may vary depending on the consumer’s age, medical condition, etc. Consumers do not have to fill in an application form and they do not benefit from disclosure from a licensed agent or exempt seller to inform them if they are not eligible to full coverage promoted in the THI product embedded in their credit card. Hence, the importance of appropriate and timely disclosure in the context of THI products embedded in a credit card.

[19] Embedded insurance products are insurance products included in another product. In the context *THI*, insurance products might be embedded in credit card programs.

The Working Group is concerned with product embedded in credit cards because they seem to offer a broad insurance coverage while placing on consumers the responsibility to understand the scope of the coverage for which they are eligible.

Example

At least one insurer offers credit cards that include free Travel Health Insurance for a short period:

Jeff and Mary are leaving on a 14 day trip. They know that if they pay their travel with the credit card they've had for 5 years, free travel insurance coverage is granted. They are glad that they will not have to shop around for travel insurance.

The important thing that they do not remember is that this free THI coverage is granted for 3-day trips only. If their travel lasts for a longer period of time, they must contact the insurer in order to extend their coverage. Also, they will need to cover the entire duration of their trip but will pay for 11 days only.

If they omit to get the additional coverage, they will not be covered for the whole of the 14 days.

The Working Group has noted an issue with regard to disclosure documents. After having activated their credit card account, consumers are provided with booklets that explain all the advantages of their credit card as, for example, the credit card program, the reward program, the THI product, other insurance products, rebates on vehicle rental, shows and hotels, etc. These booklets appear to be the only disclosure document provided for THI products embedded in credit card. The Working Group is concerned that consumers' attention is diverted by the abundance of information and that the information about THI is overshadowed by other products.

Question at Issue – Credit Cards

11. What should the industry do to ensure that all consumers get an appropriate and timely disclosure relating to THI embedded in credit cards?

5.2.2.2 Insurers' Responsibility

CCIR members have been made aware that unlicensed individuals who do not qualify for exemptions are distributing travel insurance. Ultimately it is the responsibility of insurers to ensure that any person who is acting as an insurance intermediary be appropriately licensed or qualified for an exemption. They also need to ensure that their distribution channels, including those which make use of exempt sellers, comply with retailing regulations in each jurisdiction they conduct business in.

Insurers must have effective controls and oversight of their distribution networks. As well, CCIR has long taken the view that insurers are ultimately responsible for ensuring that anyone selling their products have sufficient knowledge and expertise about the product to be able explain its features and exclusions, restrictions and limitations and/or identify where consumers should seek more expert information.

As well, CCIR members have noted in the course of their supervision activities that the insurance industry seems to have a broad interpretation of THI.

Some insurance products are marketed as THI products while they include non-emergency, routine and periodic care benefits,[20] The Working Group has also seen products designed for foreign students and individuals who are not insured or eligible for benefits under CGHIP or PHIP. Sometimes, these coverages are included as regimes inside traditional THI products.

Some CCIR members have noticed that these products/protections are sold through alternative distribution networks even though they do not qualify as travel insurance. The Working Group feels that these benefits should be offered by licensed agents as extended health insurance coverage rather than as THI products. For example, travel agents offer "travel insurance" to foreign seasonal workers. These insurance products cover, in particular, medical examination and eyesight test, pregnancy medical care and follow-ups, prescription medicine, vaccination, etc.

Questions at Issue – Insurers' Responsibility

12. How do insurers ensure that they have effective controls and oversight over their distribution channels and that proper distribution channels are used for the distribution of their travel insurance products, as well as for other coverages that do not qualify as travel insurance and which are embedded in these products?

5.3 Involvement of Third-party Service Providers/Program Administrators

5.3.1 Role of Third-Parties

Insurers commonly use third parties to facilitate the distribution and administration of THI. Third parties can act as the travel insurance program administer, providing almost all of the program functions for the insurer including product design, sales, distribution, underwriting, claims handling and customer service. Others provide specialized services such as medical cost containment services, 24/7 emergency call centre support services, or emergency evacuation/air ambulance services.

Outsourcing business functions to a third-party can provide the insurer with needed expertise, cost efficiencies and access to markets. However, when an insurer outsources a business function to a third-party, there must be adequate safeguards in place to ensure legislative requirements are being met and that there is no harm to consumers from the manner in which the third-party is discharging its function(s) on behalf of the insurer.

Insurers remain ultimately accountable for the product and for how the product is delivered and serviced. Insurers are expected to have adequate systems of controls and oversight over outsourced functions including:

- A clear strategy selecting, appointing and managing the third-party provider;

[20] Such as pregnancy care, vaccinations or annual check-up.

- Carrying out thorough due diligence of the third-party prior entering into the arrangement to provide services;
- Clear and well defined roles and responsibilities established for the third-party and including them in a written agreement which clearly defines the conditions, scope and limits of contracted services; and
- Proactive oversight of the third-party to ensure compliance with contract conditions and monitoring for instances of consumer harm.

CCIR members periodically receive complaints from the public that point to potential misconduct of third parties and suggest weak oversight or controls over these service providers by some insurers. Some of the common issues identified from complaints are:

- Lack of clarity of the identity of insurers;
- Lack of direct recourse to the insurer for information or to pursue complaints;
- Occasional use of unlicensed third-parties to adjust claims or sell products; and
- Controls over cost containment services.

5.3.2 Disclosure of Identity (White Labelling)

Consumers are expected to be able to identify the identity of the insurer underwriting their policy with relative ease. Some THI programs administered by third parties place more prominence on the identity of the program provider or the name of an association, (affiliation business), than the insurer. Websites and promotional material of these program providers give the appearance that the travel insurance is theirs and they are the party responsible for all decisions made under the policy. The text box below is a recent sample taken from a program provider.

Policy contracts and certificates often only identify the insurer in the definition page or near the end of the policy and only as the underwriter. One sampled policy had over 60 references to the program administrator and only six to the insurer. Another sampled policy had over 45 references to the program administrator and eight to the insurer, all of which occurred on or after page 29 of the policy.

The references to the program administrator typically give the appearance that the policy is issued by the administrator and that the administrator is fully responsible for all underwriting and claims decisions. For example the first referenced sampled policy had the following language:

- … payable shall be limited to $X million for all eligible insurance policies issued and administered by [program administrator], including this policy;
- The claimant shall provide [program administrator] with the opportunity to examine you when and so often as it reasonably requires while a claim is pending;
- If you fail to notify [program administrator] without reasonable cause, then [program administrator] will pay 80 percent of the claim payable.

The program administrator often uses a brand name so the policy also contains references to its legal name adding to the potential confusion for some consumers.

The Working Group is concerned that policies and promotional material provided through the use of program administrators can give a misleading representation as to who the consumer has the contract with and who is ultimately responsible for the decisions made under the contract.

Questions at Issue – Disclosure of Identity

13. What can be done to make sure that promotional material and policy or certificate documentation provided indirectly by the insurer through the use of third parties are not misleading or deceptive as to the identity and responsibilities of the insurer?

14. Are there functions that should not be outsourced to third-party administrators in order to make the roles and responsibilities clear?

15. How does delegating product development to third parties affect the insurer's role as manufacturer?

5.3.3 Lack of Recourse to Insurer

Some CCIR members have received complaints involving a THI claim where the complainant's are placed in a loop being passed off between a third-party administrators and the underwriting insurance company. In other cases, they are not aware they have recourse to the insurer to resolve a claim. The policy documentation and claims denial letters lead the complainant to believe that the ultimate decision resides with the third-party and not the insurer.

Questions at Issue - Lack of Recourse to Insure

16. What should be done to ensure that consumers are made aware of their right to contact the insurer regarding questions about the terms and conditions of the policy and claims disputes?

17. What are some of the best practices insurers could follow to ensure that there is appropriate oversight and controls over outsourced claims functions?

5.3.4 Oversight of Unlicensed Third-Parties

THI providers commonly use third-parties that are not licensed to conduct insurance business to provide ancillary services that are part of an insurance product and/or for exempt sales. When using third-parties, it is the insurer's responsibility to have adequate oversight and controls to ensure third-parties comply with legal requirements and codes of conduct.

Insurers are ultimately responsible to ensure third-parties are not conducting activity that is to be conducted by a licensed entity. Insurers need to be vigilant of functions being carried out by unlicensed third-parties that have a high likelihood for an unlicensed third-party to be acting in a role that requires licensing.

In addition, care needs to be taken when using third-parties to market/distribute travel insurance to end sellers. In some jurisdictions, the marketing of insurance products on a business-to-business basis requires the use of licensed agents; the licensing requirement is not just limited to retail sales.

5.4 Claims Management

Under ICP 19 insurers are expected to ensure the fair treatment of consumers through the full product life cycle including claims handling.

Insurers should have fair and transparent claims handling and claims dispute resolution procedures in place.

Good practices, in accordance with international standards,[21] would be to document those procedures in writing. In addition, consumers should be informed about claims handling and claims dispute resolution procedures and the formalities of claim submissions. Determinative factors in claim assessments should also be clearly explained.

In further accordance with good practices, a fair claims assessment requires appropriate competence of the claims staff (insurer and/or intermediary) and expects those that deal with disputed claims be experienced in claims handling and be appropriately qualified (in some jurisdictions handling a claim requires a licensed adjuster).

CCIR members also expect insurers to have effective controls in place over their processes, including, as mentioned above, outsourced functions, to ensure that consumers are not being unfairly treated or harmed.

Consumers raised the issue that they are being denied (or their policies are being voided) at claims time for material misrepresentation even though they made best and most honest efforts to try to complete the applications truthfully and to provide full disclosure about their medical condition. Moreover, consumers expressed the view that unknowingly misrepresenting a material fact should not necessarily give an insurance company grounds to systematically void a contract.

CCIR members believe insurers should improve their controls and oversight of claims to ensure that they are treating consumers fairly and are not denying claims or voiding policies where it is not appropriate. Furthermore, CCIR members understand insurers can be subject to fraudulent applications, however when a consumer completes an application in good faith and to the best of its knowledge and understanding, they expect the insurer to honour the contract. The Working Group feels that accepting claims unrelated to such mistakes would help maintain consumers' confidence in THI and they believe that fair treatment entails managing the reasonable expectations of consumers.

Consumers have expressed that they are uncomfortable with the common practice of an application being reviewed only at the time a claim is made. For instance, where a claim arises, the insurer might become aware of an inadequate answer in the application

[21] ICP19.

form[22] that would have rendered the claimant ineligible to the insurance product if the information provided had been in line with the medical information sought after by the insurer. Consumers might perceive this as "post-claim underwriting"[23] while in fact, it is "claims investigation". [24] We believe that better disclosure of the claims handling process would allow for better understanding and reassure consumers.

Example

Sebastian purchased *THI*. On his application, he answered "no" when asked if he had a prior medical condition. However, he had been to see the doctor 2 months prior to applying for insurance because he had felt pressure in his chest. After having undergone some tests, his doctor told him that it was probably stress.

As per the terms of the contract, Sebastian should have replied "yes" to the medical question but his interpretation was that since his doctor found nothing and no further investigation was necessary, he did not have to mention it.

During his trip, Sebastian had a bike accident. The insurer denied coverage, alleging that because of his prior medical condition he was not eligible to the insurance in the first place.

Had Sebastian replied "yes" to the general medical question, he would have had to fill a full medical questionnaire and the insurer would have been in a position to decide whether it wished to grant him coverage – and under what conditions – or decline his application.

The Working Group also found that some claimants are not aware of where to go to dispute a claim, especially claims handled by intermediaries and third party administrators. The Working Group recommends that industry consider immediately implementing better disclosure to consumers of the claims dispute processes. Adopting best practices across the industry for internal reviews of claims and ensuring that consumers are provided with a clear explanation of how to escalate a claim appeal, including how to access the appropriate Ombudservice might reassure consumers.

[22] Sometimes in their application forms consumers mistakenly give replies that do not trigger further medical questions on the part of the insurer.

[23] "Post-claim underwriting" consists of waiting until after a claim has been filed to assess, among other criteria, the insured's risk related to his or her medical condition even though the insured answered in a way that should have immediately prompted further validation in the underwriting process. When offered insurance products, consumers must satisfy various conditions which might be more or less elaborate depending on the product. Often, in THI, these criteria include age, citizenship, location of residence, general medical questions, etc. Where an insurer asks such questions, it should verify the validity of the replies before granting coverage. Choosing to validate them after a claim has been filed would be considered "post-claim underwriting".

[24] "Claims investigation" is a normal process by which an insurer obtains all the necessary information to evaluate a claim.

Example[25]

A husband and wife purchased travel insurance prior to an extended vacation in Florida. During their trip, the wife became seriously ill and died. While at the hospital, she was diagnosed with cirrhosis of liver relating to an addiction related issue and subsequently, it discovered that she had been diagnosed with such addiction many years prior to their trip to Florida. The insurer denied the husband's claim for his wife's medical expenses on the basis that her addiction was excluded under the policy.

The Court found that the exclusion clauses were to be construed narrowly, and that the wording in the insurer's contract was quite ambiguous. The wife had met the standard for "stability" in the months prior to travel, and did not engage in her addiction in the period during which the policy was in effect.

Moreover, the Court found that the *contra proferentem* rule applied. This well-established rule holds that where there is a clause in an insurance policy that is ambiguous, it should be interpreted in favour of the insured and against the insurer who seeks to rely on the clause to avoid liability. The decision also found that the language of the clause should be interpreted in an effort to give effect to the intention of the parties. In this case, it should be interpreted in favour of the insured and against the insurer who seeks to rely on the clause to avoid liability.

Questions at Issue – Claims Management

18. What initiatives could be put in place by insurers to ensure that best practices are implemented with regards to claims handling?

5.5 Complaints

The Working Group found that the majority of complaints were related to claims denials. However, the responses to the survey did not allow for further conclusions.

However, insurers are expected to have in place internal processes for handling consumer complaints and designated individuals responsible for those processes. Insurers are to disclose to consumers how those processes work and how to initiate contact. They are also expected to be members of independent ombudservices and where a dispute remains unresolved, provide the complainant with a final decision letter and information on how to contact the appropriate ombudservice or, where applicable, the CCIR member for that jurisdiction.

Question at Issue – Complaints

19. What initiatives could be put in place by insurers to ensure better claims dispute processes?

[25] *Bird Estate v. Canada Life Assurance Co*. 2001 CarswellOnt 4076 (Ont. S.C.J.).

5.6 Education

Consumers perceive that THI will fully cover for expenses related to a medical emergency occurring while travelling, as Government Health insurance plans would do if the medical emergency was to happen in their home province.

There is a strong need for appropriate disclosure for THI products, but the Working Group believes that there is also a need for a better understanding of the THI market and of the nature of THI products themselves.

Contrary to common belief, the THI market is vast and diversified and consumers should be made aware of this reality. In order to make an informed purchased decision, the Working Group believes that consumers would greatly benefit from increased general knowledge on THI. The following list gives a non-exhaustive illustration of what the Working Group believes to be the minimum knowledge and understanding that consumers should be provided with:

- There are different coverage options available, possibly not all suitable for them;
- There are many exceptions and limitations that can apply and they can vary from one product or even from one plan to another;
- What are pre-existing medical conditions, their role and their potential impacts;
- The importance of the application process and the consequences of misrepresentation, good faith or not; and
- The need to declare any change in their health conditions they may experience between the moment they filed their application and their departure.

CCIR members take the view that the industry has a crucial role in consumers' education. We acknowledge that current initiatives to better educate consumers (e.g. brochure and videos) have merit and we encourage the industry to continue improving them.

5.7 Data Collection

From the survey, the Working Group observed that, in 2014, some insurers did not monitor or could not provide breakdowns of data that regulators expected them to collect and use as part of their oversight and controls over THI products.

The Working Group believes that all insurers should collect specific metrics on, for example, claims and voided policies, and use that data to make adjustments to their product designs and sales processes to address the causes as part of the best practices they develop over THI.

Standardized key indicators should be implemented in order to allow for a better overview and help determine if there are issues as, for instance, reasons for claims denials, etc.

Question at Issue – Data Collection

20. What key indicators could be standardized and implemented to ensure proper monitoring of insurers' THI activities?

6- CONCLUSION

The CCIR welcomes the comments, suggestions and ideas of the industry and consumer associations on the issues and gaps identified in this report. Stakeholders are encouraged to identify any other issues that should be considered and how these could be addressed.

It is essential for the THI industry to adapt its practices to better reflect the concerns voiced by CCIR members in terms of market conduct and the current practices adherence to international standards. Although, some aspects of the 2015 survey do give credence to some longstanding industry positions on customer satisfaction and complaints, the Working Group was able to identify some key issues which clearly affect the fair treatment of customers as defined by current international standards.

CCIR now invites the stakeholders to provide any relevant feedback that could assist the regulators to address issues and improve the fair treatment of customers.

7- CONSULTATION DETAILS

An electronic copy of this document is available on CCIR's website at: www.ccir-ccrra.org/.

We look forward to receiving your submissions 30 September, 2016.

Electronic submissions are preferred and should be forwarded to: ccir-ccrra@fsco.gov.on.ca.

Written submissions should be forwarded to:

CCIR Secretariat
5160, Yonge Street, Box 85
Toronto, Ontario M2N 6L9

CCIR intends to make the submissions received publicly available. If you indicate that you do not want your submission or specific parts of your submission to be made public, we will treat the submission, or the designated parts, as confidential to the limited extent permitted by law.

SCHEDULE 1 – LIST OF QUESTIONS AT ISSUE

Design of a THI Product

1. What terms or expressions should be defined and standardized in order to allow a better understanding of THI products by consumers, and enable them to more readily compare products and make informed decisions?

2. What other initiatives related to product design could be put in place by the industry to help consumers better understand the extent of the coverage offered and the terms and exclusions so they can make informed decisions?

3. What type of controls should be put in place at the insurer or other levels in order to ensure that consumers of THI products are treated fairly?

Exclusion, Restriction and Limitation Clauses

4. How could the industry improve consumers' awareness about and understanding of exclusion, restriction and limitation clauses, especially pre-existing medical conditions?

5. What changes could be made to the application process to ensure that consumers have sufficient knowledge to have a thorough understanding of exclusions for pre-existing medical conditions as well as to complete an application for THI, thus enhancing consumer confidence in the underwriting process?

Suitability

6. How can the industry ensure that consumers are offered THI products that are suitable for their needs?

Medical Questionnaires

7. How can the use of medical questionnaires by insurers be improved in the context of the underwriting of travel insurance products, in order to ensure fair treatment of customers?

Disclosure Documents

8. How could insurers ensure that the information shown in the disclosure documents is limited to that which is essential, and that the format of these documents promotes a quick understanding of the fundamental information?

9. How could the industry improve disclosure documents so that they can be more easily understood by consumers?

Timely disclosure

10. How can the industry ensure that consumers are informed of the key elements of the THI coverage in a timely manner, before they make a purchase decision?

Credit Cards

11. What should the industry do to ensure that all consumers get an appropriate and timely disclosure relating to THI embedded in credit cards?

Insurers' Responsibility

12. How do insurers ensure that they have effective controls and oversight over their distribution channels and that proper distribution channels are used for the distribution of their travel insurance products, as well as for other coverages that do not qualify as travel insurance and which are embedded in these products?

Disclosure of Identity

13. What can be done to make sure that promotional material and policy or certificate documentation provided indirectly by the insurer through the use of third parties are not misleading or deceptive as to the identity and responsibilities of the insurer?

14. Are there functions that should not be outsourced to third-party administrators in order to make the roles and responsibilities clear?

15. How does delegating product development to third parties affect the insurer's role as manufacturer?

Lack of Recourse to Insure

16. What should be done to ensure that consumers are made aware of their right to contact the insurer regarding questions about the terms and conditions of the policy and claims disputes?

17. What are some of the best practices insurers could follow to ensure that there is appropriate oversight and controls over outsourced claims functions?

Claims Management

18. What initiatives could be put in place by insurers to ensure that best practices are implemented with regards to claims handling?

Complaints

19. What initiatives could be put in place by insurers to ensure better claims dispute processes?

Data Collection

20. What key indicators could be standardized and implemented to ensure proper monitoring of insurers' THI activities?

SCHEDULE 2 – INSURERS AND FINANCIAL GROUPS OFFERING TRAVEL HEALTH INSURANCE

The insurers and financial groups that confirmed that they offered Travel Health Insurance products in 2014 are:

- AIG Insurance Company of Canada
- American Bankers Insurance Company of Florida
- American Bankers Life Assurance Company of Florida
- Association d'hospitalisation Canassurance
- Berkley Insurance Company - Canadian Branch
- Blue Cross Life Insurance Company of Canada
- CAA Insurance Company (Ontario)
- Chubb Insurance Company of Canada
- Co-operator Life Insurance Company[26]
- Co-operators Life Insurance Company
- Desjardins Sécurité financière, compagnie d'assurance vie
- Empire Life
- Green Shield Canada
- Group Medical Services GMS Insurance Inc.
- Industrial Alliance Insurance & Financial Services Inc.
- Intact Insurance Company
- La Capitale assurances et gestion du patrimoine inc.
- La Survivance-Voyage, compagnie d'assurance
- Legacy General Insurance Company
- Lloyd's Underwriters
- Manitoba Blue Cross
- Manulife
- Medavie Inc.
- Northbridge Insurance Corporation
- Orion Travel Insurance Company
- RBC Insurance Company of Canada
- Reliable Life Insurance Company
- Royal & Sun Alliance Insurance Company of Canada
- SSQ, Société d'assurance-vie inc.
- Sun Life Assurance Company of Canada
- TD Life Insurance Company
- The Canada Life Assurance Company
- The Great-West Life Assurance Company
- Zurich Insurance Company Ltd Canadian Branch

[26] We considered Co-Operator Life Insurance Company and Co-Operators Life Insurance Company as one group since one of them replied in individual insurance and the other, in group insurance.

SCHEDULE 3 – BENEFITS COMMONLY INCLUDED IN TRAVEL HEALTH INSURANCE

The benefits commonly included in Travel Health Insurance products are:

- Emergency Medical Insurance, in excess of the CGHIP or PHIP:
  - Hospitalization + incidental expenses (telephone, television, etc.);
  - Emergency medical care and dental treatments;
  - Prescribed treatments or appliances (for example, prescription drugs, crutches, cane, etc.);
  - Other professionals (for example, chiropractor, physiotherapist, etc.);
  - Diagnostic services (laboratory tests, X-rays, etc.);
  - Accidental death or dismemberment:
    - Whatever the cause;
    - Accident while in a public transportation;
    - Aircraft accident.

- Transportation expenses, in excess of the CGHIP or PHIP:
  - Ambulance or taxi;
  - Return of dependent child / travelling companion to his/her province/territory of residence – includes an escort person when needed;
  - Repatriation of the insured and of the travelling companion in case of accident or sickness;
  - Transportation of a member of the insured's family or of a friend to the insured's bedside or to identify the insured's remains;
  - Repatriation of the travelling companion when the insured is repatriated to Canada for medical reasons;
  - Repatriation of the deceased person or cremation or burial at the place of death;
  - Return of the insured's vehicle or vehicle rental when unable to bring it back because of an illness or an injury;
  - Return of baggage;
  - Interruption of the travel for medical or other reasons (for example, death or hospitalization of a family member);
  - Return of the pet when the insured is repatriated for medical reasons:
    - Insured's dog or cat;
    - Insured's assistance-trained dog.

- Subsistence allowance:
  - For travel companion when the return date is postponed due to insured's illness or injury;
  - Of a member of the insured's family or of a friend to the insured's bedside or to identify the insured's body.