Travel Insurance:
The Urgent Need For Improved Regulation

A Memorandum And Submission To

The Canadian Council Of Insurance Regulators

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1. Executive Summary

As presently constituted, practices in segments of medical travel insurance are systematically unfair to clients, and lead to financial hardship – in some cases catastrophe – for thousands of Canadians annually.

The principal reason for unfairness lies in the requirement that particular applicants for such insurance are required to provide on a medical form answers to questions that are frequently vague. In addition, decisions by insurance companies on the validity of a claim by travellers are often based on non-specific, ill-defined or even unspecified criteria. For this reason, there is a high rate of denial of medical travel insurance claims across the country.

Based on Cappon's experience, misinformation provided by applicants on medical forms for travel only rarely relates to deliberate prevarication by clients. Instead, the misrepresentation, eligibility and physician consultation clauses in travel insurance contracts provide a mechanism that permits insurers retroactively to dismiss policies as null and void.

Medical travel insurance provisions in Canada are therefore systemically and inherently problematic, regardless of the character or competence of clients and their doctors.

The present memorandum analyses the issue in some detail: it explains why there is an urgent need for improved regulation of medical travel insurance. Through its recommendations, the memorandum shows how regulation may be enhanced, such that the rate of denial is reduced dramatically – without unnecessarily deep intrusion by regulators into the industry.

The principal recommendation is that the requirement of full information and disclosure must apply equally to insurers and their policies - and not only to applicants, who are then left at the whim of insurers whose criteria for claim approval are generally not transparent.

This memorandum takes the form of a submission to the Canadian Council of Insurance Regulators, together with an admonition that the CCIR review its findings and take the appropriate action in light of its recommendations.

2. Acknowledgement

Warm thanks for his collaboration in the preparation of this memorandum are extended to Dr. Jack Allingham. A distinguished family doctor, very busy with myriad activities, Dr. Allingham exemplifies both sound medical practice and profound social conscience: he has taken the time and made the effort not only to write for professional, peer-reviewed medical journals on the problems at issue in this document; but also to provide to us his advice, correction and comments on the iterations of this text as it has progressed. This submission then represents the fruit of a unique collaboration between a knowledgeable physician and a travel insurance specialist with long experience in the field.

3. Introduction

Like small business people across the spectrum of industries, insurance specialists prefer to be allowed to assist their clients and grow their enterprise in a manner as untrammelled as possible by over-regulation, "red-tape" and external interference. The author of the present memorandum is of that traditional ilk.

It must be admitted, however, that circumstances arise when the social conscience of individualists overcomes the natural proclivity to be left alone to do one's work. This is such a time.

It is such a time because the absence of adequate regulation of the travel insurance industry in Canada is causing massive uncertainty, surprise, money and grief to numbers of Canadians – especially those of older age groups who may also be on fixed incomes.

That is why an insurance broker and interested colleagues from his field as well as a practitioner from the medical domain have taken the responsibility to frame the present memorandum in the form of a submission to the CCIR. This is a submission requiring a considered response from CCIR in the form of a substantial but unobtrusive regulatory framework for the travel insurance industry.

To cast this issue in broader socio-economic terms: "markets do not automatically generate trust. Quite the contrary; it is in the nature of economic competition that a participant that breaks the rules will triumph – at least in the short run – over more ethically sensitive competitors. But capitalism could not survive such cynical behaviours for very long". (P. 36, Ill fares the Land, Tony Judt, Penguin, 2010).

Translating this truism into the terms of travel insurance in Canada: there are firms whose practices and behaviours towards insurance holders are so ethically disturbing in their self-interested manipulativeness that they threaten the sustainability of the insurance system within which they operate. This in turn jeopardizes both the welfare of the millions of Canadians who travel abroad and the integrity (and eventually the livelihood) of those, like this author, who daily work in that industry.

Therefore, through this memorandum, we submit:

- that through its action or inaction on this file, the CCIR affects the welfare of millions of Canadians
- that the CCIR must inquire specifically into matters relating to the "post-claim underwriting process" (PCU)
- that particular attention by CCIR should focus on Parts VII and XVIII of the Insurance Act, R.S.O., 1990, entitled respectively "accident and sickness insurance" and unfair or deceptive acts or practices".
- that such an inquiry by CCIR needs to determine: whether certain insurance providers may be involved in systematic deceptive acts/practices; whether recommendations must be made to responsible ministers to amend insurance regulations in this field; and whether enhanced

oversight of the conduct of those engaged in marketing these insurance products and who design PCU policies is warranted.

This memorandum is written in plain (minimally technical) language, so that it may be easily understood by interested Canadians. Following an executive summary, it provides the necessary background to issues. It then describes current status of these issues, followed by the key considerations that will determine the range of policy options, which are then articulated.

Careful consideration of these policy options leads to recommendations for the kind of positive change that will preserve the interests and confidence of the public, as well as the sustainability of the industry and the integrity of those of us who work within it.

4. Background

Millions of Canadians travel abroad annually. In many cases, the absence of adequate travel insurance for medical issues would render such mobility prohibitively risky.

In an article entitled "Just How Many Travel Insurance Claims Are Denied?" [(1)] Daw acknowledges that the primary reason for denial is invocation by insurers of their right to **retroactively** declare policies null and void, their contention that policy holders were ineligible or misrepresented at time of application. One company estimated that 55% of claims were denied on this basis.

Moreover Daw's article establishes that two major insurers have three main reasons for denials. Among these, the foremost is "*the customer not being eligible for the coverage (at the price paid) due to an inaccurate or incomplete information on the application or medical questionnaire."*

Cappon has written [(2)] that this "one strike and you're out travel insurance clause" obliges him to counsel snowbirds in particular on their extreme vulnerability to being denied coverage post facto. Cappon's additional article [(3)] "Travel Insurance Claims Denials: The Stats Are Out Of The Bag" includes a consumer travel insurance safety check list to assist consumers in assessing particular high risk clauses, which could defeat a travel insurance claim.

It is a singular and troubling fact that most insurers neither provide nor wish to collect data on the rate of such denials. Post facto denial of claims follow a pattern: clients are refused their right to coverage as having been ineligible for insurance at the price paid; or due to inaccurate responses on the application.

Denial of claims is associated with three types of policy structures: medical questionnaire; non-medical questionnaire protocols; change of health clause.

Although this report primarily focuses on the insurers' proclivity retroactively to void contracts due to an apparent misrepresentation, or an inaccurate statement made by the applicant on a medical questionnaire, there are two additional policy structures that serve as justification for the insurer to void the policy contract.

Non-medical questionnaire protocols refer to policies for which there are no medical questionnaires. Notwithstanding, applicants must correctly interpret eligibility and medical conditions that apply to the purchase process. Errors made in the applicant's misinterpretation will lead to the insurer retroactively voiding the contract.

There are also policy structures that may affix an additional clause, which may readily lead to policy voiding.

Armed with these two additional policy structures, certain insurance providers may trigger the misrepresentation clause.

For example: on a single-trip plan, if health "changes" go unreported by the insured prior to departure, the insurer may declare the policy null and void at the time of claim.

Similarly, on a multi-trip plan, certain providers demand that change of health be reported. "Change of Health" may be ill-defined, eventuating in unreported conditions which facilitate the insurer's decision to void the policy. (Note that this clause is not to be confused with a stability clause).

Seniors are especially vulnerable: they may have numerous visits to their physicians over 365 day period. Despite the understanding of both insured and his doctor that the condition is not sufficiently severe as to warrant declaration of change of health, at the time of claim the insurer may well void the contract retroactively.

The Honourable Robert Wells, Q.C., in his "Second Independent Review" of the OLHI [(4)] explains findings that cast light on issues of fairness in medical travel insurance:

- he notes that focus of adjudicators should be on fairness between the complainant and the insurer
- He notes that the underwriting process itself may be inherently flawed as described: "If …there is a claim, the insurer closely examines all of the circumstances to determine whether or not the claimant's factual disclosures at the time of the application were correct. In medical claims, the examination focuses very much on pre-existing health issues. It is easy for an applicant unfamiliar with travel insurance to miss the significance of some health fact in his or her past which could be called into question once a claim has been made. Even when an applicant has consulted with his family doctor and been assured that all is well; there may have been latent problems which were not significant to either the doctor or the patient. When such claims are being analysed by the insurer, it usually engages the services of a medical specialist whose expertise may place the opinions of the family doctor, and thus the complainant, at a disadvantage. That can happen even though the claimant has acted in good faith throughout".

When explaining motives for voiding clients' policies for misrepresentation, industry spokespeople identify three principal factors/possibilities:

- the applicant has been deliberately misleading
- the applicant has not applied herself sufficiently to the task at hand, in order to provide accurate information
- information provided by insurers at time of application were not sufficiently clear to permit an accurate appraisal and response to the medical questionnaire

Although industry representatives identify the first two of these factors as most common in claim denial, it is indisputable that insurance providers remain the sole architects of the underwriting process; and that, in the case of the third factor, clients alone bear what may be a fearsome financial burden when medical bills are not reimbursed.

As if all the factors and processes noted in this document were not sufficiently conducive to arbitrary voiding of policies at time of claim, some insurers have taken the further draconian step of obliging senior applicants to complete their medical questionnaire in an informational vacuum. Utilising a pre-scripted interview, a customer service representative from the insurer conducts a 20 minute interview with the applicant. However, the applicant has no prior access to the questionnaire and therefore is also barred from consulting his physician.

The questions may span a lifetime of medical history. Augmenting the likelihood of inaccuracy, the applicant is refused a copy of the completed questionnaire – even at the time of receipt of her policy certificate. Further aggravating this practice, the policy may include a “change of health clause”; in the instance of a multi-trip plan covering a 365 policy term, it is demanded that the applicant report ill-defined medical conditions for which they have consulted a doctor in the interim.

Failure to do so leads to voiding of the policy by the insurer .

5. Current Status

A penetrative analysis of this issue of medical travel insurance would begin, as would an epidemiological survey, with accurate data that would determine the actual prevalence of post facto claim denial.

But declining to gather this information leaves industry representatives in the position of speculating on client motives rather than on the architecture of the underwriting process.

However, estimations have been made by various reputable experts in the field. David Hartman, President of the Travel Health Insurance Association of Canada [(5)] (CBC Marketplace) avers that: "of travel claims made every year, 15,000 are denied for a variety of reasons. There are no industry numbers on how many of those denials are because of the medical questionnaire, but research by CBC's The Marketplace shows the number could be in the thousands". If Daw's figure of a 55% rate of claim refusal based on medical misinformation is accurate, then approximately 8, 000 of the 15,000 annual denials would be on those grounds – a considerable number. In those cases, we infer that the policy contracts were deemed by the insurer as **invalid from the date the policies were purchased**, even though the client is blissfully unaware of the fact.

It is also noted that there exists no independent study of the numbers of voided contracts for multiple causes. Similarly, there is no existing analysis showing demographic segmentation of post facto voiding of policy. We may assume that many of these clients most vulnerable to claim denial will be seniors and snowbirds on fixed incomes.

A further contextual issue requiring accurate data and explanation is the heavy variability of post facto denials based on medical questionnaires. Daw quotes from Will McAleer, Director of Business development of Travel Underwriters: "the rate of claims denied may differ among companies because some may exclude those policies that were deemed void from the beginning because of an error or misrepresentation on the application". His firm "does notice that errors on medical questionnaires are particularly noticeable with travellers who are senior in year and may have more complex medical conditions and multiple forms of treatment".

In such cases, McAleer's firm is rare among those that will provide a "Compassion Clause" whereby the company incorporates a cap on a claim, so that their claim is not fully denied on account of innocent mistakes in completion of the medical questionnaire. McAleer states: "in situations where a customer does not answer medical questions correctly, Travel Underwriter will not void coverage but rather consider the claim by instituting higher deductible on the claim".

Most companies have no such provision. It is likely that such companies are able to sell their insurance more cheaply, thereby gaining a strong competitive advantage over those firms which, like McAleer's, deal fairly with their clients. In this way, we may observe how in travel insurance, Judt's conclusion may operate: the cynical insurance firm procuring itself an advantage over its ethically sensitive competitors.

There is a disincentive against transparency to otherwise reputable insurance providers who would normally supply requisite information to clients at time of sale. But these companies would expect to pay out higher claims, which in turn necessitate higher premiums charged. Whereas this puts them at a distinct competitive disadvantage, their competitors, operating with inferior ethical standards, are able to offer lower premiums, gain increased market share – while continuing to deny more claims.

In this contextual imbalance, insurers will not be motivated to provide information. Claims are denied on frivolous criteria which the applicant and their doctor may have deemed clinically insignificant or based on minor pre-existing conditions.

6. Key Considerations

In considering options to efficiency and ethical proactive Canadian medical travel insurance, the following issues require elucidation:

- Are there innovative approaches in other jurisdictions that promote fairness and efficiency?
- What should be the regulatory approach to the "fine print" of medical travel insurance?
- How can we determine the true prevalence of post facto denial of claims on grounds of misinformation?
- How can the prevalence of misinformation be reduced?
- How does the Traditional Method of Underwriting (TMU) insurance differ from the new Post Claim Underwriting (PCU) approach?
- Is the Post Claim Underwriting process designed to fail?
- What are typical examples of misrepresentation clauses that require remedy?
- What are typical examples of ill-defined medical questions on travel insurance applications?
- Does the current Post Claim Underwriting (PCU) process definitively undermine ethical industry standards?

6.1 Determining the true prevalence of denial on grounds of medical misinformation

To this point in time, we have observed that insurance firms have not perceived it to be in their interest to collect adequate and comparable data on prevalence. Refusing to collect data and make it public permits the obscuring of common phenomena. More importantly, one need not act on something which is unknown; it may be more convenient for the unethical that facts remain comfortably hidden. The status quo may then continue to benefit them.

If, however, the collection and regular publication of such data were mandated, improved practice and fairness may well occur under the influence of appropriate public scrutiny – without resorting to further regulation

6.2 Is the Post Claim Underwriting (PCU) process designed to fail?

Under the PCU methodology, applicants are effectively barred from fully disclosing their medical history. This is because disclosure is constrained by a highly restrictive process consisting of checking off boxes on a medical form. There may be many grey areas, which determine severe limits on accuracy of the applicant.

In addition to being prevented an opportunity to present contextual narrative, as they would in a life insurance interview with nurse, applicants are also frequently confronted with having to interpret vague policy and insurance jargon.

The fact that only written information from the form, obtained at time of application, can be used in defence of a claim is very significant. The PCU process thus jeopardizes the applicant's right to defend a

subsequent claim as he/she is deprived of the opportunity **comprehensively** to disclose relevant medical history at the time of application.

Are insurance firms aware of having designed a process to fail?

6.3 What should be the regulatory approach to the "fine print" of medical travel insurance?

- It is clear that the fine details relating to questions and responses on the form are critical to the outcome upon claim – whether or not the questions, process and consequences of error are transparent. Yet it is clear that claim denial may occur from *"any fact that would cause us to decline your application for insurance or charge more premium than you have paid for the insurance policy"* (quotation from an actual form). The problem, of course, is that the applicant often does not know if his information is totally accurate according to the company's obscure, often unstated definitions; and that misanswered questions are only rarely related directly or indirectly to the emergent event which triggered a claim. In other words, most denials are based on misinformation that is entirely incidental to the pathology that resulted in a claim;

- The general practice of insurers: when applicants, especially seniors, contact an insurance provider for clarification on a specific interpretation of a pre-existing medical condition, the customer service representative will simply refer them on for clarification to the client's own family doctor. The physician in turn will not have a complete grasp of the specific definitions and concerns of the particular insurance company in play;

- the misrepresentation/non disclosure clause in policies does not effect reciprocity, whereby insurers also have equal obligation to the applicant to be transparent and accurate: many medical questionnaires, depending on the ethics and quality of the insurer, may be comprehensive and clear – or they may be ambiguous, vague, ill-defined, misleading;

- At time of application, insurers generally make no effort to verify information received. Only at the time of claim will they scrutinise for accuracy the information received;

- Insurance providers frequently require applicants to agree to a clause stating that they will have consulted their physician for clarification as required. They may then add the contradictory statement that "you must be stable based on the definition of stable in this policy regardless of the opinion of your physician or any other person who may provide a medical opinion". Not only does this place the doctor in an invidious position; it is also disingenuous, in that only one party to the contract knows precisely how insurers will interpret a medical condition at time of claim.

- Only at claim time will clients and their doctors discover the correct interpretation of questions they sought to answer most honestly and thoroughly on the form. This practice represents for

unprincipled insurers a “get out of claim card free”, a Hammer Clause open to abuse by providers.

Note that this practice contrasts sharply with the process relating to TMU products such as critical illness, disability and long term care, by which insurance companies may write directly to the attending physician’s office to obtain medical information pertinent to the underwriting of the risk. In travel medical insurance, responsibility is shifted from company to client and her doctor, for whom, incidentally, there is no proposed payment from the company for the doctor’s services in this application.

The regulatory approach to the “fine print” of travel insurance must remediate all these major issues.

6.4 How can the prevalence of misinformation be reduced?

Currently, under the “physician clarity clause” and the “misrepresentation clause”, providers “download” all responsibility to applicants to interpret the insurer’s questionnaires not only honestly but also accurately. However, applicants’ accuracy is contingent upon the explicitness of criteria being expressed by insurers at time of application. But these criteria are not explicit.

This frequently leads judges and the OLHI to support claim denials based purely on the strict legal wording of a policy contract, tying adjudicator’s hands with regard to considerations of “fairness” or the right of expectation of coverage.

The prevalence of misinformation leading to claim denial may be reduced markedly by eliminating poorly defined medical questions on travel insurance applications.

For example (one among a legion of such illustrations): an insurer may inquire whether an applicant has a “bowel disorder”. It may add “including but not limited to” a sample of severe conditions – which the client and his doctor know that the applicant does not have. At time of claim, however, the claim may be denied because two benign polyps were removed at colonoscopy.

Under the current obscurity, applicants and physicians are placed in the invidious position of having to speculate on correct responses: if an insurer intends subsequently to deny a claim based on removal of benign polyps or the presence of haemorrhoids, let it define it clearly and specifically under the rubric of “bowel condition”. Full and plain disclosure from insurance providers should be the rule – and would reduce dramatically the prevalence of misinformation.

If the insurer chooses to avoid such specificity, it may exercise the option to remove the condition from the list of denied disorders. As a rule of thumb, if the insurer fails to define a condition, the misrepresentation clause should not be invoked.

If a specific medical condition is listed, the applicant, carrying precise information relating to polyp, haemorrhoid or other issue, can consult with his doctor correctly to recall diagnosis and treatment. Cappon writes in “The Medical Post” that in the absence of this specificity, doctors who attempt to help

their patients by completing an ambiguous medical questionnaire on their behalf are *"walking into a minefield"* [6]. Doctors should not be required to speculate about variable interpretations from each insurer in Canada regarding a *"symptom, disorder, generalised condition".*

Dr. Jack Allingham, experienced and respected family physician, has noted an illustration in his excellent article on travel medical insurance in the "Canadian Family Physician" [7]: *"one company asks those who indicate that they have had general cardiac screening if their ejection fraction is less than a certain number…The applicant can check off only yes or no. Potential clients are advised, sometimes in small print, to consult their physicians if they are uncertain about particular questions. The utility of this advice depends on the physician having a good understanding of how insurers work, and awareness that there might well be a discrepancy between the physician's definitions of an issue and that of the insurer…Clarity and transparency are, however, essential in maintaining a good industry reputation and are the best approach to avoid regulatory action".*

It is possible that some insurance providers, with assistance from medical/legal experts, may cleverly craft policies intended to defeat potential claims. CCIR will need to determine the extent of such deceptive and unfair practices.

Finally, there is a need for more explicit warning labels when applications for insurance are filed. There may be a minority of applicants who naively attempt to mislead the insurance company. The industry could do much more to discourage potential untruths with conspicuous labelling with regard to the consequences of misinformation. The insurer must make it very clear to applicants that even though insurers do not verify information at the time of application, if there is a claim, the insurer will closely examine all of the circumstances to determine whether or not the claimant's factual disclosure was accurate. If not, the insurer would then void the policy and any medical expenses incurred would be paid by the applicant.

Also, there is a need that applicants are made aware of the consequences of innocent misrepresentation. In particular, they must be informed that claims may be denied merely on the basis of incorrect information on the form that related in no way to the pathology surrounding the claim. Aware of this fact, some clients may prefer to seek insurance from more complaisant firms.

Elimination of uncertainty and ambiguity – deliberate or otherwise – on travel medical questionnaires will go far in reducing misinformation on completion of forms, and consequent high rates of claim denial.

6.5 How does TMU insurance differ from the new PCU approach?

For purposes of clarity and comparison, it is useful to emphasize the unique and radical departure represented by the Post Claim Underwriting (PCU) approach in relation to Traditional Method of

underwriting processes (TMP). Under the normal TMU method (for life, critical illness, disability, long term care):

- Issue of a policy involves comprehensive and meaningful collaborative exchange of information between the insurer and the applicant. Insurers thereby obtain relevant information that assist in determining their risk;

- collaborative exchange of information might entail completion of medical questionnaires at time of application by physicians or nurses, results of x-rays, attending physician statements, ECG, MIB inquiry etc;

- **most significant is that applicants are encouraged to provide a complete narrative, rather than simply and only checking boxes in relation to ambiguous and vague wording under the PCU system;**

- under the TMU methodology, given its thoroughness and clarity, a misrepresentation clause allowing insurers unfettered power retroactively to declare a contract null and void may be perceived as equitable.

6.6 What are typical examples of misrepresentation clauses that require remedy?

A misrepresentation clause may read as follows: *"I declare that I meet the eligibility requirements. Where I was unsure of medical history as it relates to these requirements, I have verified it with my physician…I agree that if I do not meet both the eligibility requirements or if **any** material misrepresentation or evasion is contained herein, the XYZ insurance company will void my policy and no coverage will be provided".*

The applicant would need to be able to reference the definition section of the policy to discover legal meanings, such as: *"**material fact** means **any** fact that would cause us to decline your application for insurance or charge more premium than you have paid on the insurance policy".*

One inaccurate response can void a policy. As we have observed: in the vast majority of cases, claim denials are related to misanswered questions which are unrelated directly or indirectly to the emergency event that triggered a claim.

Also in the vast majority of cases, claim denials were related to non-**"Eligibility requirements"*–** that is, on misanswered questions beyond the eligibility section, which typically stream applicants into qualification categories. Put simply, even though these applicants "made it through the eligibility/underwriting door", their claims were harshly denied.

We have set out above an example of GI function as illustrative of the results of unfair misrepresentation clauses in relation to eligibility or "material fact". Dr. Allingham, in private correspondence with the present author, makes the following observations in relation to the use of this clause by insurers:

- *"The smorgasbord of exits potentially provided by the medical record, and the insurer's free interpretation of entries, is a concern. The major one is clarifying the advantage insurers have in fitting medical notation from records into their usually undefined or vaguely defined interpretation of terms";*

- *"Clients completing the questionnaire on their own may have an incorrect picture of their own medical condition, sometimes because that's what they erroneously took away from a consultation with their physician in which a diagnosis was given, or because the physician, for various reasons, used evasive or alternate language with the patient";*

- *"On the other hand, Physicians helping a patient fill out the questionnaire may have different views about medical conditions than do insurers. Advice may be given to answer NO to questions about diagnoses of hypertension and high cholesterol because of ignorance about precisely how the insurer is defining the conditions. Take hypertension as an example. Major medical protocols will say that to define a patient with high blood pressure, there should be three successive readings where one of the numbers is over the standard limit of normal (140/90). The patient may have had only one elevated reading, so the patient was not so labelled by the physician, no prescription given, no lifestyle alteration discussed. Advice for the medical questionnaire was given accordingly."*;

- *" further difficulty emerges in deciding how to respond to medical stability questions….Changes in medications over a specific period of time are very broadly defined by insurers, including dropping or adding a drug, changing the dosage – even if it is lowered because of progress in treating the condition, and even a change from a brand name to generic.";*

- *"Of surprise to most physicians might be the insurance consequence of pm prescription medications, where the patient alters, according to a medical protocol, frequency or dosage of a drug depending on a lab result or clinical condition. An example would be asthma, where a daily inhalation of a corticosteroid is matched with a pm prescription of a bronchodilator, for use only when there is major flare up of symptoms. This is standard protocol. At least one insurer has declared that use of a pm medication is inherently unstable";*

- *"the medical chart will provide the insurer with opportunities…they may see that singular blood pressure reading with a slight, fleeting elevation, that one elevation of cholesterol tests. They may seize on musings by the physician about drinking too much on occasion…such a comment may well prove sufficient for insurers with an alcohol abuse exclusion to deny a claim" even if the issue is "not supported by empirical data such as lab tests, or even quantitatively specific. The concern is that undefined or vaguely defined initial screen questions or in exclusionary clauses in the fine print of policies,* ***become miraculously well defined after a claim and the medical records are in hand.****"*

These examples of manipulative interpretations of misrepresentation clauses, as provided by an experienced medical practitioner, should give rise to specific remedies by regulators.

6.7 Innovative approaches in other jurisdictions that promote fairness and efficiency

If we can find no alternative to the current dysfunctional nature of the medical travel claim process in Canada, that could be an argument for the status quo. However, other countries have found a better way. We should be attentive to their examples.

In the U.K., when travel medical claims are in dispute, the Ombudsman is currently finding in favour of the complainant in around a quarter of the cases – far more than in Canada. The reasons are:

- the English ombudsman will determine whether the facts withheld by the client would have made a difference to the underwriting decision;
- whether the applicant knew about the condition/information in question;
- whether the questions asked by the insurer were sufficiently clear and specific that it is reasonable to have expected the applicant to have disclosed the information.

An English spokesman for the UK Financial Ombudsman Services said [7]: *"we always factor in the individual circumstances, so even if the insurer has not technically done anything wrong, we may still conclude that it has not acted within the spirit of the agreement."*

*** Please see appendix 2 for a clarification of eligibility clauses and questions in contradistinction to less significant medical conditions**

7. Policy Options

The foregoing analysis leads to consideration of policy options that will be both fair to consumers and reasonable for insurers.

7.1(A): RECIPROCITY

Misrepresentation and non-disclosure clauses could be made reciprocal, so that the onus would fall upon the insurer at time of application to show transparency in the medical questionnaire and in wording of the policy.

Questions and policy interpretations must be sufficiently clear that they elicit accurate responses.

Returning to our example of a "bowel disorder", insurers could continue to ask such questions. However, in case of dispute, unless it was absolutely transparent which specific medical conditions were pertinent, the misrepresentation clause could not be invoked to deny a claim. In our example, therefore, a claim could not be denied for the presence of benign polyps unless there was a requirement to disclose that information at time of application.

7.1(B): CAUSALITY

In addition to the above, the misrepresentation clause could be invoked only when a substantial causal connection exists between the faulty information on application and the medical expenses incurred. Presumably, an unreported benign colonic polyp would not obviate a claim for an MI.

7.2: MISREPRESENTATION AND ELIGIBILITY

In this option, in addition to the reciprocity clause detailed in option 7.1(A), the misrepresentation clause could be invoked only in limited circumstances in relation to eligibility requirements.

All other issues not related to eligibility requirements would allow insurers to trigger a misrepresentation clause only when there was "fraud, concealment or deliberate misstatement".

What industry response to these options may be anticipated? One could be forgiven for assuming that option 7.1(A) above would already have found its way into the Insurance Act; and that ethical insurers would not wish to resist sharing the responsibility with clients in assisting them to answer questions and interpret conditions correctly.

Unfortunately, the experience of travel insurance brokers is instead that certain providers object to this provision. The grounds for their resistance appear to be in demonising their clients. Insurers appear willing to condemn clients who "misrepresent": if they provide incorrect responses on one question, even if unrelated to the medical emergency for which they stake a claim, they cannot be trusted on any other. Not only is this condemnation offensive to clients; it also suggests that their clients are either dishonest or indolent. In other words, insurers prefer to ascribe problems to the first two motives for

misinformation described above; and not to the real, systemic causes that they themselves have created.

(For a clarification of the differences between eligibility requirements and lesser medical issues, see appendix 2)

7.3: REGRESSIVE SOLUTION

All insurance would be underwritten at time of issue. This option represents reversion to traditional method of underwriting (TMU) where the medical information is verified at the time the policy is approved and issued. (For further clarification of Post Claim Underwriting, see page 11 under section 6.2 “Is post-claim underwriting process designed to fail?”).

8. Recommendations

8.1 Review of findings by CCIR

We recommend that the CCIR set rapidly in place a method of reviewing and confirming the salient findings of this review; and that, if these findings are corroborated, it inform all interested parties including: provincial and territorial ministers responsible; insurance companies and their associations; and regulators of insurance across the country. Sharing the results of such a review should constitute an opportunity to advise all parties, especially insurance providers, on the ethical standards required in this industry.

As a corollary to its review, CCIR should determine to what extent current travel insurance practices by insurers are deceptive, intended to defeat potential claims by deliberate obscuring of questions and policies. (See key considerations above).

8.2 Implementation of Option 1

We recommend that CCIR and its entire membership implement both sections of option 1 as above: only in the presence of reciprocity and causality could a misrepresentation clause be invoked by insurers.

8.3 Implementation of Option 2

We recommend incorporation of the reciprocity clause identified in option 1A. Additionally that the misrepresentation clause could only be invoked by the insurer in relation to misanswered eligibility requirements/questions. Non-eligibility questions would require proof of fraud for the insurer to be in a position to trigger the misrepresentation clause.

8.4 Removal of the physician clarity clause

This briefing has shown how the **contractual requirement** to involve clients' doctors in formulating responses to the application form places both client and doctor in invidious and unfair positions. The clause must be removed from medical travel policies.

8.5 Mandate collection and publishing of data on denials

We have observed that insurers prefer not to collect data on the prevalence of claim denials based on the issues raised in this monograph. The reasons are: not being explicitly aware absolves them of an ethical responsibility to alter practice; altering practice towards fair and ethical approaches may not be seen as advantages for unethical firms; public relations problems that may ensue.

CCIR is advised to mandate collection and publication of such data, including stratification of these data by demographic group and region, as well as by insurance firm.

8.6 Institute progressive practices in arbitration as in the U.K. model

We have observed that the more equitable approach taken in England by its ombudsperson for insurance results in a fairer distribution of results between clients and insurers.

Canada should emulate this model in its arbitration practices

8.7 More explicit warning labels on medical forms

Insurers should be urged to provide more conspicuous warnings of the consequences of incorrect information.

In particular, applicants must be clearly informed that any error, even if quite unrelated to the cause of medical problems while travelling, may be used by the firm to declare the policy null and void.

8.8 Mandate fair and transparent marketing of travel insurance products
New insurance sales strategies have combined three separate clauses that may eventuate in claim denials. This practice should/must be amended.

9. Final Word

The future evolution of the travel insurance industry will depend very much on an enlightened response from regulators and governments, as well as from insurers themselves.

It is quite clear from this brief that the industry is moving rapidly in the wrong direction, exposing its clients arbitrarily to unfair voiding of policies and refusal to honour legitimate claims – often leaving the unsuspecting and trusting to lose their pensions or their homes.

Will we have the judgment and foresight to reverse the unfortunate trends detailed in this document?

The benefits of well articulated reform will extend to all participants: clients, brokers, governments and insurance companies.

10. References

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11. Appendices

APPENDIX 1

Biographical note on the author:

Bruce Cappon, is President and co-founder of First Rate Insurance. A licensed Ontario broker, Mr. Cappon has over 35 years experience in insurance.

Currently specialising in providing innovative travel insurance recommendations to seniors, snowbirds and other Canadians, Mr. Cappon has written numerous articles on travel insurance for both medical publications and popular papers and magazines, as well as advising his own clients on a daily basis. He is also in high demand as a speaker on medical travel insurance – including at insurance conferences.

Bruce Cappon strives to improve travel insurance processes for the benefit both of clients and for sustainability and ethics of the industry.

APPENDIX 2

Clarification of the difference between eligibility questions/clauses and less significant medical conditions?

"Eligibility requirements" may appear separately labelled as such in a medical questionnaire format; or alternatively in the policy or application where no policy questionnaire is required. These medical requirements typically relate to very severe diseases which would render the applicant ineligible to purchase the policy. A pertinent analogy: if your house were on fire, you certainly could not purchase fire insurance.

If the applicant is deemed eligible, there are additional questions that stream applicants into various risk categories. These questions relate to far less serious medical conditions.

<u>Example of eligibility questions:</u>

[] In the past six months prior to the application, have you had a stroke?

[] In the 36 months prior to the application, have you been diagnosed with, treated, or ordered by a physician to take medication for three or more of the following conditions:

a) Heart disease/condition;
b) Liver disease/condition;
c) Lung disease/condition;
d) Diabetes (requiring medication)

[] Do you have a terminal condition or metastatic cancer?

Example of "Non-Eligibility" questions:

[] In the 24 months prior to the application, how many of the following medical conditions have you been diagnosed with, treated or ordered by a physician to take medication for?

a) Kidney;
b) Gastrointestinal bleeding;
c) Pancreatitis;
d) Chronic bowel disease;
e) Bowel obstruction.

[] Was your last medical check-up more than 24 month s ago?