Travel Insurance:
The Urgent Need for Improved Regulation Governing Contract Voidability

A Memorandum for

The Canadian Council of Insurance Regulators

May 2015

From Bruce H. Cappon,
Travel Insurance consulting specialist

Table of Contents

1. Introduction

Informed by the experience of travelling Canadians, and by recent advice proffered by travel insurance specialists such as the author of the present memorandum (Cappon: Travel Insurance: The Urgent Need For Improved Regulation – A Memorandum and Submission to the Canadian Council of Insurance Regulators, March 2014), insurance regulators have been exercising diligence in re-examining travel insurance processes and problems. For this they merit plaudits from consumers and the industry.

Similarly, the Travel Health Insurance Association (THIA's) advice to Canadians to take the process of travel insurance very seriously is well founded.

In the case of Ontario, current regulations have sought to reduce the tendency of insurers arbitrarily to void contracts of travellers through "warranties". Revised regulations no longer permit this type of free interpretation.

Despite recent efforts of regulators, however, it must be conceded that serious problems regarding travel insurance contract voidability remain; and this is the focus of this brief to provincial regulators.

The key to fairness and efficiency in the travel medical insurance industry may be summarised as follows:

THE CRITICAL ELEMENT IN ANY REGULATION OF MEDICAL TRAVEL INSURANCE IS THE IMPERATIVE OF RECIPROCITY BETWEEN INSURERS AND CLIENTS. EQUIVALENT ACCOUNTABILITY MUST APPLY TO THE ACCURACY, COMPLETENESS, AND TRANSPARENCY OF INFORMATION PROVIDED BY BOTH CUSTOMERS AND TRAVEL INSURANCE COMPANIES.

The considerable breadth of the voidability problem may be captured anecdotally through two surveys. A recent formal survey by THIA[(1)] indicated "that 18% of respondents have inadvertently provided inaccurate health information on travel health insurance forms." The inaccuracies would have been sufficient to void their insurance claims."

The present author has carried out informal surveys among participants at conferences at which he has been invited as expert speaker. Among a cumulative total of hundreds of attendees, the majority made errors sufficient to disbar them from coverage by insurer practices under current regulatory frameworks.

This brief is intended to indicate to regulators several balanced solutions. Preserving fairness for the insurance providers while providing a fighting chance for consumers armed with a mechanism to contest unfair claim denials.

2. Background

2.1 Responsibility and consequences of error

The Travel Health Insurance Association (THIA)'s advice to Canadians to take the purchase of travel insurance very seriously is well founded. . Evident is an individual travel insurance health survey commissioned by THIA[(1)] indicating that "18% of respondents have inaccurately provided health information on travel health insurance forms"- something that can void an insurance policy.

The final word rests with the insurance provider who has the sole discretion to determine whether there are grounds to declare the contract null and void; Their customers may have purchased the insurance with the utmost good faith and due diligence. Yet, through no fault of their own, ran afoul of a particular insurer's unclear interpretation of what constitutes a "material misrepresentation".

The penalty for even a trivial non-eligibility related misrepresentation or inaccuracy with most (but not all) insurers can be as if **no coverage was purchased**. The consumer will likely be responsible for paying their own medical bills.

2.2 Insurance Regulations: Misrepresentation/Non-Disclosure – Duty to Disclose

Are Ontario's current insurance regulations governing contract voidability by insurers a failed fix for a former similar issue? Government formerly sought to reign in insurers' capacity to freely void their customers 'policy contracts? It's my understanding that pertinent regulations in the current context of the Insurance Act (Ontario) were enacted as a solution whereby "warranties" were formerly utilized by some insurers to such an extent that even trivial breaches lead insurers to declare policy contracts void. The revised regulations no longer permitted this type of free interpretation. Instead, it replaced it with language confining the voidability of a contract to statements made by the applicant, which were "material" to the contract.

Have we gone full circle where policy contracts are once again freely voided but now based on the insurers free interpretation of a "material fact"?

2.3 Vagaries of the Post-Claim Underwriting Process

Consumers need to be more cognizant of the uncertain nature of the Post-Claim Underwriting process under which most individual travel policies are purchased.

Insurance providers have downloaded the initial responsibility of underwriting onto their customers. It's a Do-It-Yourself (DIY) process. Based on the information provided by the insurer, it's the customer who will initially determine if they are eligible for coverage (not the insurer) and often at what price.

Essentially, issuance of a policy/certificate is limited, denoting approval of the consumers' right to pay premiums; Whether or not insurance coverage has been in force will be determined in the unlikely event a claim is submitted.

Furthermore, certain policy contracts may be unfairly voided based on the insured not reporting a "change of health" over a single trip or annual trip plan over a one year term.

3. Key Considerations

3.1 The disclosure conundrum

Section 308 (1) of the Ontario Insurance Act stipulates, in part, that applicants must disclose "every fact within the person's knowledge that is material". Under the typical application process, this is a technical impossibility. Applicants' capacity for disclosure is rigidly confined by the format preferred by insurers. Often, clients plead: "I just want to be up front and tell the insurer everything I know honestly about my health". The harsh reality – as this consultant regretfully must convey to sincere consumers - is that they can only do so on the stifled terms offered by the particular insurer. This naturally induces anxiety.

In most cases, they must check "Yes/No" boxes or respond to formulated questions or decipher complex policy language. On the application, any narrative added by the applicant to provide full and complete disclosure or to further clarify an issue typically results in the application being rejected out of hand by the insurance provider.

3.2 The nature of fact

The Insurance Act fails to define a "material" fact, simply that the matter is a question of fact "to be determined by the courts". Where does that leave consumers? In legal limbo.

3.3 Precariousness of resolution

Non-litigated resolution of a consumer's right to coverage is precariously left balancing on a pin head.

3.4 Insurers de facto arbiters of "fact"

It follows that Insurance providers are then able to create at will their own customized versions of what constitutes a "material fact". The end result is that insurers may essentially contract themselves out of responsibility for their clients 'inaccuracies. Policy wordings may vary referencing misrepresentation/non-disclosure and may include breaching any or all of the following scenarios:

- Any inaccuracies, erroneous, incorrect, incomplete statements or representations (these typically go beyond eligibility requirements);
- Charge a higher premium than was paid;
- Where the insurer's decision would have been "different".

3.5 Unilateral determination of outcomes

Certain policy contracts may openly assert that the insurer has the unilateral or arbitrary right to declare the contract null and void for breach of a material misrepresentation. With other contracts, it may be assumed but they are silent on this significant issue.

3.6 Unbalanced accountabilities

Both the Insurance Act's regulations and policy wording make the potentially false presumption that a non-disclosure of a material fact is uniquely the fault of the applicant. Insurers are de facto contracted out of responsibility for having provided the pre-requisite information required for consumers to avoid the arbitrary rescission of policies. Depending on the ethics of the insurer and the quality of the product, the consumer may have been provided with transparent, comprehensive and clear information while their competitors may have provided ambiguous, vague, misleading or information that is open to broad interpretation.

It is likely that such companies are able to sell their insurance more cheaply, thereby gaining a strong competitive advantage over those firms which deal fairly with their clients. In travel insurance, therefore, cynical insurance firms are procuring 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. This puts them at a distinct competitive disadvantage as 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 may not be motivated to provide transparent information. Claims can be – and are - denied on frivolous criteria which the applicant and their doctor may have deemed clinically insignificant or based on minor pre-existing conditions. **Remedial legislation would address this inequitable and regressive imbalance. Insurance providers whose documentation was ill-defined, ambiguous and subject to broad interpretation would be disallowed from voiding their customers' contracts.**

4. Current Status

Post Claim Underwritten insurance and Incidental Sales Products, distributed through an alternative channel, are now proposed as providing many Canadian consumers access to insurance that would otherwise be unavailable to them. This procedure may indeed offer additional options.

However, based on the foregoing analysis, our assumption is that this incidental process for sale of travel insurance will lead to increased frequency of claim denials. Many insurance providers will switch to the alternative method since it reduces underwriting costs. But they will retain ability to manage the claims process. And in that process, regulators must insure that, while bad behaviour does not profit, claims are not denied in instances in which the client has acted in good faith and with due diligence.

Let us place the debate on Post Claim Underwritten Insurance in context and then give it a more accurate epithet: "Do-it-Yourself" Underwriting.

In November 2008, CCIR and CISRO issued a joint paper entitled "Incidental Selling of Insurance Report". The disingenuousness of segments of the industry was illustrated by the fact – highlighted in the report - that the insurance industry simply denied that "Post Claim Underwriting" existed in Canada. From our perspective, it was alive and is still flourishing in Canada. The following information is a quote from that report:

"The debate generated around post claim underwriting is of significant concern to the ISIWG and is an interesting example of these complexities. It is the understanding of some stakeholders that the consumer's eligibility for coverage is validated at the time of the claim – a practice known as "Post-Claim Underwriting". Yes, but are they validated at the time of application by the insurers? The insurance industry states that this practice does not exist in Canada and that applications are immediately underwritten if eligibility questions are answered correctly. Meanwhile insurers apply a practice known as "claim investigation" where they validate the different elements of a claim, including the validity of the answers provided to the eligibility questions. This practice sometimes reveals that eligibility questions should have been answered differently at the time of application and that the proper answers would have initiated a more extensive underwriting process. Insurers then have an opportunity, depending on the situation, to void the contract and, at the same time, the claim".

The insurance industry's argument as advanced is purely driven by semantics. The insurer generally does NOT do interactive underwriting. In the case of travel insurance, it's the consumer who has to decide with the eligibility responses whether they are eligible. There is no double-checking by the insurer to validate

their customer's responses and typically no secondary underwriting is offered. Moreover, insurers may void policies for not only misanswered "Eligibility" issues but also responses of a more trivial nature (non-eligibility issues). The reality is very straight forward. The process by which the insurance industry is describing as **not** a "Post-Claim Underwriting" system is unarguably a Do-It-Yourself (DIY) underwriting process. Based on the information provided by the insurer, it is the customer who will initially determine if they are eligible for coverage and if so at what price.

Call the process what you will. The nomenclature of Do-It-Yourself (DIY) - rather than Post-Claim Underwriting or Point of Claim Underwriting – is much closer to the reality that consumers face. (See appendix: "At a glance: the do-it-yourself underwriting process") By whatever name, the process entails all the usual potential risks of untrained individuals performing tasks for which they receive little or no training.

Statistics on just how many medical claims are denied ranked by demographic groups is unavailable to the public.

From our own observations and considerable experience, we would put that figure at a significantly higher number than the 18% quoted in the THIA survey for those applicants who inadvertently provided inaccurate health information of their Health Insurance Forms – thereby potentially voiding their policies. I have categorized ambiguous, misleading, ill-defined medical questions with the highest likelihood of leading to a contract being voided under the following question classifications:

a) Time Warp
b) Tip Of The Iceberg
c) The Numbers Game
d) Your Guess Is As Good As Mine
e) Catch All
f) Back To Birth

5. Policy Options And Recommendations

The critical element in any regulation of medical travel insurance is the imperative of reciprocity between insurers and clients: equivalent accountability must apply to the accuracy, completeness, and transparency of information imparted by both customers and travel insurance providers.

In our brief to CCIR, in the section on options and recommendations" (Cappon, 2014), we observed that that insurers must be governed by equivalent standards of disclosure of "material facts" as those that apply to clients. In the case of insurers, this means that questions and interpretations of policies must be sufficiently clear as to elicit accurate responses from honest applicants.

The revisions to the insurance legislation proposed in this section will, if implemented, accomplish the key goal of reciprocity. They will ensure parity and fairness of the insurance contract with respect to duties of both parties to disclose facts materials to the policy.

The issues of "materiality" is central to the proposed revisions. Legislators should amend relevant sections of the Act such that whatever is designated in the Act as being a "material" to the contract would apply equally to both parties. Thus, the insurer would be in a position to void the contract if material facts were breached by the insured. Conversely, if the insurer failed to provide the material facts to the client then the insurers would be barred from rendering the contract invalid.

Appendix 2 outlines the key points of the current insurance act (Ontario) pertaining to disclosure in travel insurance contracts. It is these points that require modification.

When the language contained in current legislation is augmented or substituted by the following wording (as edited into appropriate legal terms), the amended legislation will have fully achieved the reciprocal nature of the contract that has become exigent.

5.1 Misrepresentation and Non-disclosure

Duty to disclose: an insurer shall disclose to the insured every fact within the insurer's knowledge that is material to the insurance.

Non-disclosure by insurer: if an insurer fails to disclose or misrepresents a fact material to the insurance, it may not render the contract invalid as against insured.

Rights of the insured: any fact or omission of the insurer resulting in imperfect compliance with any provisions of this Act **does not** render a contract voidable

Materiality, how decided: the question of materiality in a contract includes any fact, error, omission, inaccuracy, misstatement, incorrect or incomplete statements or representations where disclosure of the material fact would have influenced the judgment of a reasonable insurer or insured either with respect to:

-Setting the premiums payable for that particular policy; or

-Determining acceptable risk; or
-Determining the extent of coverage which would be insured

5.2 More Explicit Warning Labels

In our earlier brief (Cappon, 2014, section 8.7), we recommended more explicit warning labels relating to material misrepresentation and conditions of voiding of contracts by insurers. Please see Appendix I (At a Glance etc..) for details regarding information that insurers should be required to provide as components of warnings.

In summary, these detailed notices to clients should be conspicuously documented by insurers through several means:

a) Marketing material;
b) Policy contract;
c) "Acknowledge and Consent Declaration" signed by the insured.

5.3 Mandate Collection And Publishing Of Data On Claim Denials

Our previous brief to CCIR (Cappon, 2014) recommended the mandating of collection and publication of claim denial data, particularly with the DIY underwriting process, by which coverage is only validated at the time of claim. Consumers would be in a more favourable position to determine the potential for claims being honoured if, prior to purchase, insureds were provided audited data from insurers.

Since my original report in March 2014, the Travel Health Insurance Association (THIA) has published what some could consider dubious statistics on individual claim denials.

THIA appears to be relying on a survey commissioned of KPMG which could be charitably characterised as flawed in its methodology and sub-optimal in its interpretation by some in the industry. One could reasonably have expected that a business founded on actuarial science would present a more factual report.

A major finding indicated that the vast majority (95.3%) of Canadians who purchased travel health had their claims paid.

Among the methodological deficiencies of the analysis:

- It is based on a "national online survey of 1,007 Canadians conducted September 11th-12th, 2014". There is the possibility of selection bias: how were the 1,007 selected?

- Why are there no independent audited statements of claim denial by the insurers or -at minimum – major insurers?

- In the THIA-commissioned study, did the 5% reporting denial include those Canadians who had their claims denied due to non-eligibility? This datum is of critical significance: even though voiding is one of the primary reasons for claim denials, sometimes insurers may not include these in their denial stats on the spurious grounds these policies in effect "did not exist" and were retroactively rescinded (voided).

- In the survey, categorization by demographics (age bands) would be essential. Seniors would be expected to have a much higher denial rate due to a more complex purchase process and typically more pre-existing medical conditions.

- Categorization of medical insurance from Trip Cancellation, baggage, etc.

Stratification of claim denials based on:

- Percentage of voided policies by age groups (for non-eligibility or change of health reasons);

- Percentage of claim denied for customers 'failure to meet pre-existing stability requirements;

- Other reasons.

The study indicates that $138 million was paid in claims to 103,000 travellers = $1,339.80 per claim. We would need to segment the number of claims denied by demographic group and the value of those claims. Insurers may pay small claims but larger ones may be more problematic.

Finally, as indicated in this brief, my informal data indicate that a much higher proportion than the 18% admitted by the survey made inadvertent inaccurate responses.

Interpretation of the survey by THIA:

One must ask whether THIA has been responsible in its public interpretation of the survey results.

After release of the study, president of THIA at the time was quoted in a major Toronto newspaper [(2)] as stating that: "14% falsified the application"; and yet apparently only "half did so to get a cheaper rate". So what was the motivation for the balance of the 7% who also falsified their documents? Are they pathological liars?

This same article quoted the President as saying of those consumers who had their claims denied "lying is a strong word...let's say they're intentionally making a mistake".

If this comment is accurately reported, it would be construed as facetious, flippant and derogatory to travel insurance honest customers.

The salient observation on data collection was made in the previous brief (Cappon 2014, section 8.7)) and it bears repeating here: "certain insurers may 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."

The mandating of collecting and publicly releasing accurate and comparable data on travel insurance claim denials is fundamental to industry public accountability and to a properly reciprocal relationship between clients and insurers. It is our strong recommendation that insurance regulators in Canada mandate collection and publication of such data, including stratification of these data by demographic group and region, as well as insurance firm.

6. Conclusion

In our previous brief to CCIR (Travel Insurance: The Urgent Need for Improved Regulation – A Memorandum and Submission to the Canadian Council of Insurance Regulators, March 2014), we offered options that would eventuate in a more balanced process for the underwriting of travel insurance – one that would be advantageous both to consumers and to the industry.

The current brief, in response to developments since our initial submission, and to efforts by regulators, brings the issue of "post-claim underwritten" insurance products into sharper focus. We have shown that:

- Post-claim underwritten insurance products, while carrying some advantages, will undermine sales of traditional products, as an unintended consequence
- Insurers may well escape underwriting costs while still benefiting from claims profits
- Under the claims process respecting these products, many honest consumers will continue being innocent victims of denied claims
- Most significantly, remedial legislation of the type expressed in this brief would address this inequitable and regressive imbalance. The thrust of regulation must be that insurance providers whose documentation is ill-defined, ambiguous or subject to broad interpretation would be denied ability to void customers' policy contracts. Through the rebalancing suggested here, both the industry and its clients can flourish.

7. References

(1) "Report shows that travel health insurance saved Canadians more than $138 million – THIA – November 25th, 2014
http://www.thiaonline.com/cgi/page.cgi/_article.html/Latest_News/Report_shows_that_travel_health_insurance_saved_Canadians_more_than_138_million

(2) "As Dollar Drops, Snowbird Insurance Rising: Mayers" – TheStar.com - November 11th, 2014.
http://www.thestar.com/business/personal_finance/2014/11/11/as_dollar_drops_snowbird_insurance_rising_mayers.html

8. Appendix I

At A Glance: The Do-It-Yourself (DIY) Underwriting Process

Potential clients must be made aware of the consequences, as follows, of the uncertain nature of the Post-Claim Underwriting process (DIY), under which most individual travel policies are marketed.

a) Insurance providers have downloaded the initial responsibility of underwriting onto their customers. It's a Do-It-Yourself (DIY) system. Based on the information provided by the insurer, it's the customer who will **initially** determine if they met all the eligibility requirements for coverage and, if so, typically at what price.

b) The transparency of the insurance product, the information provided by insurers may be comprehensive and clear and concise or may be ambiguous, vague, ill-defined, lengthy and misleading;

c) By all means, consult your doctor for assistance in completing the application (and possibly a lawyer where required) but be aware that **your physicians' advice may not be accepted by the claims examiner**;

d) Know that simply because you have a policy in hand doesn't guarantee the right to coverage until a claim is filed and approved in this context, at claim time, a consumer is vulnerable as policy contract can be readily invalidated. This may occur irrespective that the quality of supporting customer information provided by the insurer prior to the consummation of the contract. An "accurate response" by the insured may be open to a wide range of conceivable interpretations.

e) The insurance provider will initially typically "tuck away" the application into "their back pocket". Only if and when a claim is filed, will the insurer very closely examine the accuracy of the claimant's factual disclosures;

f) Based on current insurance regulations and typical policy wording, it will be the insurance provider who has sole discretion to determine whether there are grounds to declare the contract null and void; Their customers may have purchased the insurance with the utmost faith and due diligence. Yet, through no fault of their own, ran afoul of a particular insurer's unclear interpretation of what constitutes a "material misrepresentation".

g) The penalty for even a trivial non-eligibility misrepresentation or inaccuracy with many (but not all) insurers can be as if **no coverage was purchased**. The consumer will likely be responsible for paying their own medical bills;

Note: This is an expansion of my recommendation from my original submission advocating under 8.7 more explicit warning labels. If the foregoing language was incorporated with the appropriate legal language in

"Acknowledgement and Consent Declaration", it would go a long way to raise the awareness of the consumers to their extreme vulnerability to the potential of a claim denial.

9. Appendix II

Insurance Act, R.S.O. 1990, c.I.8

9.1 Duty to disclose

308. (1) an applicant for insurance on the person's own behalf of and on behalf of each person to be insured, and each person to be insured, shall disclose to the insurer in any application, on a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within the person's knowledge that is material to the insurance and is not so disclosed by the other. R.S.O.1990,C.I.8,S.308(1).

9.2 Failure to disclose, general

(a) subject to section 309 and 312, failure to disclose or a misrepresentation of such a fact renders a contract voidable by the insurer. R.S.O.1990,c.I.8,S.308(2).

(I believe the section below also pertains to travel insurance)

9.3 Materiality, how decided

The question of materiality in a contract of insurance is a question of fact for the jury, or for the court if there is no jury, and no admission, term, condition, stipulation, warranty or proviso to the contrary contained in the application or proposal for insurance, or in the instrument of contract, or in any agreement or document relating thereto, has any force or validity.R.S.O.1990,c.I.8,s.124(6).