Travel medical insurance

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In an era of extremely high medical costs for Canadians who require emergency medical care when traveling outside the country, travel medical insurance has become a requirement. An investigation by journalists from CBC's Marketplace suggests that clients might often believe that they have coverage when in fact they do not.[1] The number and proportion of denied claims is unclear, as the data are apparently not tracked in a coordinated way by the industry. One industry source "guesstimated" that the overall claim denial rate might be about 3% (written communication with Mr David Hartman, President of the Travel Health Insurance Association, March 2012). It seems likely that this is much greater for specific demographic groups with higher–risk profiles, like seniors.

While one can argue that travel medical insurance issues should entirely be the responsibility of patients, physicians are sometimes involved in helping patients with the initial application and are inevitably involved in the claims process. Physicians need to be aware of the nuances of travel medical coverage and how these affect patients and, potentially, their own practices.

This commentary assumes insurance clients have primary care physicians. Those who do not might have considerable difficulties both in getting travel medical insurance and, especially, in successfully claiming insurance payment.

Financial risks for Canadians who travel

Canadians needing emergency care while out of the country can count only on the financial contribution from their respective government health insurance plans (GHIPs) and what they would have paid if the illness had occurred domestically. The various GHIPs will at best contribute payments to physicians and institutions outside of Canada for a limited range of services, at the GHIP rates paid in province.[2] This leaves those with serious illnesses, requiring emergency facility visits or hospitalization, with the risk of incurring considerable financial obligation to pay their medical costs. The case of the late skier Sarah Burke illustrates the considerable sums involved for intensive care.[3]

Aside from the minority who have out-of-country group coverage from work or from another third-party policy, Canadians must purchase supplementary medical insurance when they travel, or gamble at great risk, especially if they have existing medical issues.

While all Canadians who travel should be aware of the need for medical coverage, the most vulnerable travelers are seniors. This is because they are more likely to suffer illnesses or accidents requiring medical care, and many have pre-existing conditions that might not be covered under the insurance they purchased.

Medical insurance application forms for those at considerable risk should never be filled out without consulting an insurance-savvy attending physician.

Insurers

Many companies are in the business of insuring Canadians against medical costs incurred while traveling. Although a few have dominated the market, there are many players. More than a dozen insurance companies underwrite travel insurance. Some of these act as underwriters for different "front-end" retailers who sell the policies but do not manage the claims end. For example, CIBC sells emergency travel medical insurance, but both the application and any subsequent claim go through TIC Travel Insurance Coordinators. Medipac is a prominent company insuring Canadian "snowbirds," but Manulife is the underwriter, as it is for the Canadian Automobile Association and many others. While some medical insurance companies are member based, others are corporations in the business of maximizing profit for shareholders, who are protected in part either by not insuring those with serious risks or by applying sufficient premiums to compensate for the risk.

This commentary is not an attack on the legitimacy of the industry, but rather a caveat emptor.

There are differences among the companies offering travel medical insurance, especially the "look and feel" of the initial application forms. However, many conform to the general model described here.

Companies reduce risk either by not covering any pre-existing conditions or, more commonly, by accepting some pre-existing conditions with important qualifications, such as a required period of "stability" and "control."

The prospective client is asked to fill out a health questionnaire. This might be in print or online. This process will exclude some from consideration at the outset, based on age and some key conditions that are deemed *uninsurable*. Some of the latter group might be eligible at higher premiums after an individual assessment offered by some companies. For those still "in," but with some declared medical problems, there might be further, more detailed questions, often repetitive in subtle ways,

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which sometimes require a fair bit of medical knowledge to answer. For example, one company asks those who indicate that they have had general cardiac screening if their ejection fraction is less than a certain number, assuming the client will understand and have access to this datum. 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 the insurers work, and an awareness that there might well be a discrepancy between the physician's definition of an issue and that of the insurer.

Which patients are stable and controlled?

The first essential thing for physicians to know is how the insurer defines the period before the onset of the policy when patient medical conditions must be "stable" and "controlled." Although it is generally 3 months, this can vary from 2 months to a year or more. This medical trouble-free period before activation of the policy at travel time is called the *red zone* here. In the red zone, one must be stable and controlled according to the insurers' definitions.

The industry does not appear to be particularly interested in the attending physician's view of the patient as medically stable or controlled. This is understandable, as there is potentially too much subjectivity involved. Instead, they use "proxies," which are quantifiable and, for them, predictive of risk. For those with lung disease, use of 2 or more inhalers is one such proxy used by one large insurer. An affirmative response allows the company to avoid, or prorate, the risk of those with serious lung problems, even at the price of excluding or negatively rating some applicants who do not have important clinical risk. Note that the current medical protocol recommending inhaled steroid maintenance along with a short-acting bronchodilator rescue inhaler for the inevitable flare is flagged here, even if the patient only uses the bronchodilator on very rare occasions. Another proxy used by many insurers for lung disease risk is use of intravenous or oral steroids; for heart issues, use of diuretics like furosemide is one proxy that is often used.

The main proxy for risk used by the industry to assess stability and control of disorders is medication change. This is defined very broadly as any alteration in medication type, format, or dosage, prescribed or recommended, during the red zone before the onset of the insured period. Other proxies for stability and control of medical conditions might include the following: emergence of any symptoms, diagnosed or not; changes to or increases in any symptoms for declared conditions; laboratory testing carried out, ordered, or even suggested; and any referrals to specialists suggested, done, or booked.

Assuming the applicant "passes" all the screening questions to the point of generating an insurance quote, the policy is contracted. In reality, this is not a contract guaranteeing that the applicant has coverage, but rather an agreement that he or she can proceed to pay the premiums. It is only when clients successfully make claims that they know that they have been covered. The next step if medical misfortune occurs while traveling is making a claim.

Claims

Initial acceptance of the claim by insurers might be reversed based on company interpretation of later reports from the client's physician or the client's claim form. This claim form will likely not only require details of the expenses incurred, but will also require the client to revisit questions asked on the initial application. This time, there might be a query to cross-check earlier declarations. The client might be asked specifically to list not only all medications taken, but also the date and nature of the last alteration to or discontinuation of a medication. Note that this question might not have been asked in the original forms completed in applying for the insurance. The physician of record will also be separately contacted. The specifics of what is asked of physicians are not published. They likely vary with the company, the claim, and the initial questionnaire record. But one can assume that the queries will be variations on the themes noted, and might ask what the last test ordered was and when it was ordered, and what the last specialist consultation was about and when it was. A copy of the entire medical record might be requested, or at least a listing of every visit and its nature, every prescription issued, all tests suggested or ordered, any referral discussed or ordered, or any report received. The underwriter will then review all the sources of information, plus any additional information from medical records pertaining to the travel medical claim. Any discrepancies in submitted forms will jeopardize the claim.

Physicians are inevitably involved in the claims process and should be aware of the nuances of travel medical coverage and how these affect patients as well as themselves. Any discrepancies between client-supplied information and that provided by the physician will be noted and might adversely affect the claim. Any information from the physician that suggests a violation of the company's stability and control definitions might also result in a rejected claim.

So how does all of this affect patients and their physicians?

Patients

Successful and timely reimbursement for travel medical expenses is more complicated than many believe. Any uncovered errors in the initial application, whether

deliberate or inadvertent, can result in claim rejection. The insurer will carefully look for discrepancies between stated health status on the application, and that discovered when the claim is vetted.

Despite both understanding the questions and using complete candor when filling out the application, clients might still be denied restitution on a claim. While there is a prerequisite of complete agreement between what the applicant answers on the application form and what is written on the physician's medical record, rejection of a claim can still occur if 1 or more of the following is found by the company in the medical record:

- A test result came in within the red zone. This might not be permitted, considering their definition of stability and control. Also, if the physician ordered a test that is yet to be done, or even mused in the medical record about doing one, the claim could be rejected. Similar issues pertain to specialist referrals.
- The medical record notes some adverse change in symptoms of the disorder in question during the red-zone period, even if this did not generate testing, referral, or medication alteration. Similarly, the record might note symptoms, diagnosis, or treatment for a new, seemingly peripheral issue.
- The physician has prescribed a relevant medication in a manner that the company views as suggestive of instability or poor control. As-needed or episodic medications in whole or in part might cause a claim to be denied, although warfarin or insulin adjustments are specifically permitted by many insurers.
- The patient's medical record lists a condition that the company believes might have contributed to the one for which a claim has been made. For example, a person recorded as abusing alcohol, even long before the red-zone period, might be denied a claim for bleeding ulcer treatment, even if there were other reasons for the bleed.[4] By extension, one wonders about bleeds occurring in patients taking antiplatelet or anticoagulant medication. Many conditions are potentially interrelated in some way, so this area is a minefield one has no way of clearing before receiving a claim rejection.

Physicians

Concerns about travel medical insurability can lead to patients avoiding necessary medical care. Insurance-savvy patients might avoid seeking needed medical help for months before embarking on a trip in hopes of preserving their insurability. Physicians might also recommend not undergoing elective screening if the testing or results will fall within the patient's insurance red zone. Ironically, these avoidance responses could increase the risk for insurers.

Physicians might face a dilemma in completing insurance company forms when there is a discrepancy between the "spirit" of the question and the specific wording on a medical record. This becomes more acute the more the physician knows about what is behind specific company questions. The request by some companies for a copy of the medial record, later if not initially, removes the temptation and should rightly temper the urge to provide any potentially incomplete answer to questions posed.

As the considerable time involved in guiding patients through initial applications is not covered by provincial health plans, appropriate compensation for the physician must be negotiated, unless the patient has opted for one of the supplementary expense plans offered by some practices. If the physician assists the patient in completing the application, physician liability in case of claim rejection and subsequent patient litigation against the physician must also be considered. The Canadian Medical Protective Association has addressed this issue by stating that they will "generally assist ... members in the event of medico-legal difficulties arising in Canada as a result of professional work done in Canada."[5] Specific cases dealt with by the Canadian Medical Protective Association are noted in their publication "Forms and Reports: The Case for Care."[6]

Medical insurance claims can turn adversarial. Companies are obliged to look for reasons to deny or, at least, modify a claim. Some patients will naïvely attempt to mislead the insurance company in their applications, being unaware of the thorough nature of claims scrutiny. More often, patients just do not have the expertise to minimize their risk of unintentional error in answering questions.

The insurance conversation alerts the physician to the patient's travel plans, with possible attendant medical needs such as immunization and prescription extensions. As physicians are an integral part of the claims process, they need to be aware of the nuances of the business in order to protect patients from unintentionally putting their insurability at risk. Sometimes this will involve informing patients that their health issues come first, and that travel medical coverage will not be feasible for a specific interval, or indeed, ever. At other times it involves planning the timing of elective investigations, referrals, and medication alterations. For snowbirds, this often means completing all necessary "changes" by the end of September for those hoping to travel insured in the new year.

Improvements would occur if applicant questionnaires were clarified. Company definitions of terms should be easily accessible and comprehensive. Forms should ideally permit applicants to respond that they do not know, rather than just the current yes or no response options. However, this is simply impractical. If this uncertainty about how to properly answer a question emerges, it is time to consult the primary care

physician, who in turn might have to consult the potential insurer to clarify the many nuances.

Claims questionnaires should not delve into areas not covered in the initial application, or present questions in a novel way. This comes across as a "gotcha" tactic. What needs to be known for proper risk assessment should be part of the prepolicy assessment. Clients should be clearly advised to have their physicians verify the symmetry of their answers with their medical records.

Patients and physicians should be aware of all issues that might affect stability and control. Physicians need to be wary of "permissive" models of prescription writing. Apart from that expressly permitted by the company, as in warfarin or insulin use, patient-adjustable dosing might endanger patients' stability and control rating. Instead of empowering the patient, it might just empower the insurer to reject a claim.

Conclusion

The many outlined ways to end up unexpectedly uninsured suggest that patients with pre-existing conditions ideally need to be specifically evaluated and individual premiums set through an individual in-depth assessment, which is offered by some insurers. Although potentially much more expensive, this at least exposes all the information to the insurers up front, and their policy, if offered, would presumably be less likely to be contested in the event of a claim. The second best option, and the practical choice for many, is completing a general application in close cooperation with the primary care physician. Filling out an application in the office of a travel agent is an unacceptable risk for those with pre-existing medical conditions.

The right of insurers to choose and rate individual risk factors is not an issue here. Variances in target populations, acceptable risk mixes, and rates are necessary in a competitive industry. Clarity and transparency are, however, essential to maintaining a good industry reputation and are the best approach to avoid regulatory action.

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Competing interests
None declared

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