CARDIAC PATIENTS AND TRAVEL INSURANCE AFTER AGE 65

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DR. MACKENZIE: Speakers who spoke this morning related to healthcare matters touched on the idea of health insurance as particularly related to travel. One of the problems in Canada has been the change in the economic climate and an intensification of scrutiny of health care claims, particularly those involving travel outside of Canada. At the present time provincial medical plans cover costs only at provincial medical care plan rates, and do not reimburse claimants for expenses that occur outside of Canada beyond that level of cost. The demographics of Canada results in a large of the Canadian population, particularly in the age group over 65, going south to the better weather during the winter, particularly to Florida and Arizona and California. Because of the age group involved in this travel, occasional medical emergencies occur and these result in extreme expenses. These are now being transferred to the private health insurance market. Many of these problems are cardiac in origin, so we have asked the chief medical director of Blue Cross of Canada to speak on this subject: Travel insurance and its underwriting in travelers over the age of 65. Francois Sestier is a cardiologist and professor of medicine at the University of Montreal.

DR. SESTIER: I'll be speaking here on behalf of the Blue Cross of Quebec, and my colleague Dr. Coutu who is also a cardiologist has been helping me in setting up what we are going to show you in a few minutes. As Ross told you both speakers this morning made a mention to the difficulty of coverage when you travel south and the cost of this coverage, and we all know that the medical expenses in the States have been rising over the last few years.

The decreased coverage by the provinces is really the issue which makes really this topic a la mode. There is also very aggressive competition amongst the insurance companies. Just the number of companies involved in travel insurance has been rising from 20 to 55 over the last few years. Also rising is the interest of the public industry in the field. Also, a few changes in the market have been occurring. With some insurance companies, for example, changing during winter with little warning to the applicants, so that all patients mainly have to do some shopping and be very careful about the coverage they are getting.

I'll go through the size and nature of the problem and then I’ll review the options available to increase the quality of the coverage for all the patients. Then I’ll finish with a few words about assistance and repatriation.

The size of the problem really can be illustrated with a few claims. These are the top claims paid by Blue Cross in Quebec during last winter. This poor lady died after 30 days in hospital. The family would have to pay if she was not insured over US$200,000. And 40% of all these bills are medical fees. These top five claims totalled nearly 3/4 of a million dollars, just making the importance of good coverage very clear. The population at risk is the aging population over 65 years old, staying outside the country for more than 6 weeks.

So the "snowbirds" are really the people at risk for coverage, at risk for hospital admissions and for high medical expenses during their stay abroad.

What happened in Quebec about over a year ago is that the coverage for medical expenses abroad has been changing with a maximum of $480 per day, as compared to 6 of the bill excess of what was paid in Quebec before. I can review this one example for exactly what it means. For the poor lady who died after 30 days in hospital, the reimbursement politics was that the family should have gotten to pay $105,000 because nearly $100,000 was paid by Quebec Medicare. Nowadays, only $23,000 are paid by Medicare, and the burden on the family would have been much heavier. This patient was covered, but just these figures can show you the drastic change occurring 18 months ago on coverage for travel insurance.

What can you do if you want to cover an older patient when staying for several weeks abroad? Several companies will request stability prior to departure as a prerequisite to confirm coverage abroad. Other companies will have riders and will refuse these programs and have been developing over the last three years under-
Why is there so much difference between the cost of travel insurance and the conditions: exclusion, and riders, and so on; why is there so much difference? In thinking about it, I went back to the different program options and found there are two different types of travel insurance programs. Some companies are willingly involved with low-risk people traveling abroad just for one or two weeks for winter holidays. And if most of the customers or the applicants to this insurance company are buying this type of contract, you can build up a reserve and have a very generous or very appealing program going to the snowbirds, or the people who are staying for long periods of time and in the older age group.

Voyageur has the biggest part of the market in Canada and Quebec. If you go south and drive your own car, you’re not offered this policy. You cannot write Voyageur and apply for an insurance policy; you have to go through a travel agent. This company can then offer an appealing contract of three months stability prior to departure to insure coverage. But when you phone them — and I did that just to be sure — they make the point that if the medication has been changing, even the pathology, if those have been changing over the last three months, you’re not covered. You’re not considered as stable. So to be stable, you have to have exactly the same medication, no hospital admission, no emergency room visit, no change in medication over the last three months. If you do have this stability, you then are covered 100%, whatever happens.

Voyageur perhaps is aiming at a new program, but they didn’t disclose this program. There was an ad in the newspaper saying that by October 19 there will a new program they developed for snowbirds.

Other companies are also selling travel insurance only through travel agents, aiming at the same population of winter vacationers. Full coverage is insured if the patient has been stable for 60 days, and also mentions no change of pathology alone. We have seen catastrophic histories or anecdotes of people denied coverage because of change of medication, and this should be stressed to all electives or to a friend or patient when they do apply for travel insurance.

The advantage probably of this program is that it includes coverage for malignancy, and some patients after chemo-therapy who are stable, they could foresee a stay of a few weeks or a few months in the sunny area of the United States, and they could be covered if they have been stable for two months.

The problem begins when...

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...population needs to have restriction to the coverage to stay in business. We have seen many programs occurring for one year; they’re very appealing, and before the end of the year they disappear, because they couldn’t really function; they were just too generous. So how can you cover an older patient or a cardiac patient for a long stay? You can raise your premiums, and certain insurance companies have been doing so. I have seen in this year raises up to 100% as compared to last year. You can limit reimbursements, as one company is doing; John Ingle is doing that: limiting reimbursements to 80% of all emergency care given abroad. You can also add riders of different types. You can also select the low-risk patient by the underwriting process.

Nomad is very popular because all that they want is emergency admission, even if you have a previous medical condition, you are covered, but they will limit 80% of the cost linked to this pre-existing disease.

Desjardins is popular in Quebec, ranking third in popularity for travel insurance. They have riders for people with previous myocardial infarctions, angina, previous stroke, cancer or malignancy. There would be no coverage for these medical condition even if they are stable, after the age of 61, if you stay for more than one month, or whatever the length of the stay is, over 76 years old.

What we have this winter for Blue Cross is exclusion of coverage for the age of 65 if the patient is not stable for 3 months prior to departure. After the age of 65 and for more than 24 days, any condition diagnosed or treated prior to departure won’t be covered. That’s really a very strict rider. When we introduced this rider a few years ago, people were not happy about it and had a lot of claims and cases which were not clear: was this one a treatment before if the patient has nitro pm, was this considered a pre-existing disease with medical treatment, and so on. We found an easier solution with underwriting. We’ve developed underwriting only for the last three years, although it was proposed many years ago. At first we extended full coverage to patients if a medical questionnaire was satisfactory; they could
be offered full coverage or a long stay, even if there were
only six weeks since surgery. All the patients recovering
from myocardial infarction or coronary bypass surgery
were excluded. Even the best, most generous programs
were requesting two or three months of stability with
no hospital admission. So while people were recovering
from myocardial infarction, while they were recovering
or coming back after surgery, were denied any type of
medical coverage and they were just covered by the
time they had to go back to work. That was a very tight
and unfair limitation for this type of patient, and we did
feel there was some space for underwriting, and we
tried the first two years with a program designed to
cover only cardiac patients: full coverage for cardiac
patients for a long stay if they were over 65 years old
the first year, 60 years old the second year. Last winter
we had been developing the same type of full coverage
with underwriting process through a questionnaire for
all medical conditions.

I'll summarize this form. I do not expect you to read this
form which has been hated by most of my colleagues.
There are very precise questions on the cardiovascular
status; on the first page is cardiovascular status, second
page are other medical conditions.

When we ask about medical status and cardiovascular
status, we ask, for example, precise reports of any is-
chemia, significant ischemia. We ask for a scan figures
and we are really limiting coverage if we have a low
ejection fraction. There was a question this morning
about the size of the heart; there is still a very bad sign,
mainly up to a myocardial infarction, and when the left
ventricular diameter exceeds 65 millimeters, for exam-
ple, we are very cautious about full coverage, because
we know that event rate is really proportional to the
dilation of the left ventricle. The more dilated the left
ventricle, the more events will occur in the next few
weeks or months. Left ventricle arrhythmias are also
questioned, and we ask if the patient had arrhythmias,
what was the report at the last Holter?

We also ask questions about the quality of secondary
prevention. There have been reports over the last three
years of regression studies in coronary disease, showing
that the patients having excellent or very aggressive
secondary prevention, do well for a few years; they have
far fewer events, up to 80% fewer cardiac events over
two or three years. So if the patient has a very good
quality of secondary prevention, we treat them well and
we extend their coverage, because they are in a low-risk
group.

Patients awaiting surgery for aneurism of the aorta
obviously won't be covered. We also ask questions
about lung disease, diabetes, neurological state, and if
the patient is on the waiting list for surgery. I have been
talking about the Canadian system this morning, and
the waiting list for elective surgery is sometimes long,
and if the patient is on the waiting list for gallbladder
removal or whatever, we exclude that risk because the
patient obviously can need emergency surgery in the
States.

We ask for injection fraction, because as you know,
when ejection fraction of the left ventricle comes down,
the event rate and the mortality does increase sharply.
This is the same type of relationship that you have been
shown with left ventricular dilation and we do take care
of these measurements by echo very precisely.

The difference with disability insurance with life insur-
ance is that you don't have to wait for a life span to see
if we are right or if we are wrong. So, first year, this was
really the pilot study. We received 327 questionnaires,
and we accepted over 200 of them, 67%. We extended
full coverage to some cardiac patients, over 2/3 of the
applicants, and we said, "Why not to go on?" So, the
following year, we extended accepting, we accepted
over 90% of the applicants. We received 558 question-
naires; we accepted 530. And the experience was still
good, so last winter we increased the full coverage to a
medical questionnaire for disease for all kinds of medi-
cal conditions, we accepted 73% and we see what is the
result. With good luck we'll have it at the end of the
winter season, when we compile the admission rate in
hospital in the U.S. during that period abroad. This is
the figure which is accepted as normal for any person
over the age of 65, admission rate is in the range of 5%.
Some years if's lower, but in the 5% range.

What we want to do with a medical questionnaire is to
select the low risk of patients which have admission
rates either the same or lower; and you see the first year
we accepted 67% of the applicants with a 2% admission
rate. The second year we are perhaps a bit more gener-
os, and we have a 3.4% admission rate on the extra
questionnaire. Last year we started this new program
with full coverage for any type of medical condition
considered as low risk with a 2% admission rate. Two
times less than the general population over age 65. You
can go even by age and see that the people who have
been patients or the travelers who have been accepted
for full coverage, even in the older age group, the people
between 75 and 79, 70% of them were accepted for full
coverage with an admission rate of only 2.8%. We had
perhaps the best program for older people (over age 80)
in Canada last winter. That's the reason why we had so
many older people; 71 signed up for and were accepted
for full coverage, 58%, and the admission rate is still acceptable.

In conclusion, I’ll say a few words about assistance and repatriation. We do feel that coverage has to be confirmed to the insured within 48 hours, so we have a hotline and we monitor all the hospital admissions while the patient is in the hospital. This just gives you an idea of the number of hospital admissions, peaking perhaps to 80 or 100 admissions per month in January and February. When the patient has been admitted into the States, it’s in the plan, in the contract that’s signed, they agree to repatriation once they are stable. And over the last season, from September '92 to April '93, we did 42 repatriations mainly for cardiac conditions, but for some other conditions, as well. We are using only air ambulance, with private jets, jets chartered from a chartering company in Montreal, and having more business now and having more patients to bring back from Florida, we are able to combine flights. We have many flights with two stretchers in the same private jet, decreasing the costs sharply, and making the air ambulance repatriation very comfortable and very rapid and less of a burden than bringing a stretcher in a regular flight with all the regulatory problems involved even with Air Canada, which is very cooperative. So by combining two patients in one air ambulance, in one private jet, we’ve been able to decrease very significantly the cost of ambulance repatriation.

Over the last three years for different reasons we have been taking over the control and the surveillance and also the training of all the people working for us on this air ambulance repatriation. This is a lot of work, but it shows here that we have been doing very few repatriations on regular flights with stretchers and really favoring the air ambulance repatriation, having kept the costs down by combining transportation. We now offer assistance in repatriation to nine other insurance companies, and we expect this number of air ambulance operations to more than double this coming winter. We now have three jets based in Montreal and one at a military base in Florida.

Before leaving the topic of travel insurance, I must say there are many things a traveler should check before signing for travel insurance. Some programs have limits of age. Some others have riders for pre-existing conditions, pre-existing disease, for surgery, elective surgery, patients on the waiting list for elective surgery. The patient has also to be aware that sometimes coverage is limited or is only granted for 100% for hospitals acknowledged by the insurance company, for example, Blue Cross/Blue Shields has a list of hospitals in Florida. If you sign up for these hospitals, you’ll be fully covered, but you’d be covered for only 80% if it was your choice to go to some other hospital. Obviously, the emergency patient won’t be denied coverage.

Reimbursement rates can change from company to company. Nomad, for example, is limiting reimbursement to 80%. Daily enrollments can change a lot from one insurance company to the other. Repatriation services are more or less generous. We pay directly to the hospital and the physicians at Blue Cross, and we get reimbursement by the provincial Medicare later on, which makes the process much easier for the patient. On other things like dental care, maximum length of coverage, telephone assistance, at costs ranging from the $700 range to over $3,000 for a stay of 6 months abroad for patients age 70, a wide range of premiums that can be paid. Half the applicants now do some shopping before buying travel insurance, because of limitations or riders or problems occurring with some of their friends or relatives. It is a fast-changing market, and for example, the premiums table for Blue Cross and Desjardins changed last week at the beginning of the season. Voyageur will change its program two weeks from now. The patient has to verify he can afford the travel insurance, but he must also verify that he is well covered and won’t be exposed to a huge bill on his return from vacation. The patient should be aware also that there is a limit to coverage by many companies, mainly for the older age group. So when you go to travel, you have to be well covered. Obviously, there are some more risky ways to travel. For the older age group we are involved with, and many of the cardiac patients, there is alternative underwriting as one alley? we have been exploring for the last three years.

Now I’ll be glad to answer any questions.

DR. MACKENZIE: Merci, Francois. This paper is now open to questions from the audience. Please use one of the microphones and identify yourself.

UNIDENTIFIED: Francois, one of the concerns we’ve seen in the papers here is related to the requirement regarding change in medications, as well as the exclusion factors in some policies. Do you have any comments on that as to how you underwrite that and judge risk?

DR. SESTIER: That’s very true. As I mentioned, the insurance companies, and I phoned them personally, do stress that any change of medication, even if the patient has been stable and it was the choice of the physician, will be considered a criterion of instability, and the patient won’t be covered. So the patient sometimes has a certificate from the cardiologist saying they are stable.
and can travel, but the physician just changed medication, such as adding a cholesterol-lowering product, changing the medication, and this is black and white on the contract: the patient will be denied coverage. This makes the underwriting process very secure and very reliable for the patient, who has prior to departure a letter saying that whatever happens, it will be covered.

UNIDENTIFIED: Suppose I change the medication because of side-effects just from one type of beta blocker to another, would that...

DR. SESTIER: Yes, that's considered a change of medication, and I asked these very precise questions to some of these insurance companies. And they applied to some answer, "Yes, it's instability." Although the patient is clinically stable, but the medication has been changing. So I guess the patient had to be aware of this problem.

DR. CUMMING: I'm wondering, do you do any of the monitoring of air evacuations. We've run into stumbling blocks, for example, a lawyer has a cardiac arrest on the golf course in the U.S. and they're thinking of putting in an internal defibrillator and we tell them we can do that in Canada and we'll air ambulance them back, and then we find out he's on an ordinary ward without constant monitoring and all this kind of nonsense and you call the doc and you tell them, "I am a cardiologist; I think I can sort of help you get this guy back home." And he says, "Not interested; we're putting in the defibrillator tomorrow. Too bad." End of story. How do you handle that?

DR. SESTIER: That's a very good point, Dr. Cumming. Thank you for making that point, because that's perhaps the main problem when we decide the patient from the nurse's follow-up of the case, we know that the patient is stable enough; we've got this angiogram of course he needs surgery, but according to our criteria, he could safely be flown back to Canada. But the surgeon in the States wants to do the surgery there. And sometimes the family says it's very risk business. So very often we have to discuss with the surgeon or the cardiologist and explain that our air ambulance is like a flying ICU, a flying CCU, and we have a cardiologist aboard, and whatever happens, we can handle it. We have oxygen; we have pacemakers; whatever happens, we can handle it. We have had no incidents on the patients who have been brought back to Canada either after an MI or after unstable angina. It is sometimes a problem dealing with physicians. In one occasion, we sent the jet with the physician with no acknowledgement; the patient was refused to be transported. But when the physician went to the hospital, he discovered the patient was on a regular ward. Discussing the points with the physician, he showed his credentials and the type of equipment on board. A few hours later the transport was allowed, and the patient was coming back. But sometimes it's like a pirate expedition to bring back the patient. In some of the cases, we sometimes have the family on our side, explaining to the family that perhaps the patient could be managed in a more comprehensive manner and would like to be offered a second look at this case and perhaps listen. Perhaps there is no urgency to do coronary bypass surgery tomorrow. Why not come back to Canada and discuss it later? Sometimes the family is very helpful.

DR. MCKENZIE: Thank you very much, Francois.