This document is issued by the Equal Opportunities Commission (EOC) for the purpose of public consultation. **The EOC invites the public and the insurance industry to provide views on the issues raised by 20th March 2003.** Responses should be directed to the Equal Opportunities Commission:

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For the attention of the Policy Support and Research Unit

The responses from the community will help the EOC to formulate a set of Insurance Guidelines to be published for further consultation and implementation.

CONTENTS

A. INTRODUCTION

Under each of Hong Kong's anti-discrimination Ordinances, two of the key functions of the Equal Opportunities Commission (EOC) are to work towards the elimination of discrimination and the promotion of equal opportunities for all. This includes the elimination of discrimination and unnecessary stereotyping in the provision of goods, facilities and services to the public. The provision of insurance by insurance companies falls within this field. The provision of insurance by employers falls within the field of employment, and is equally protected under Hong Kong's anti-discrimination laws.

Every person has the right to be free from discrimination in insurance in the fields of employment and provision of goods, facilities and services on the grounds protected by law. Given that the function of insurance is to reduce the individual's risk by pooling it with the risks of other individuals, risk assessment and underwriting criteria are necessarily based on assumptions about risks and group behaviour that may appear to be in conflict with human rights principles.

The anti-discrimination laws recognise that insurance practice necessarily involves the classification of risk and that premiums and policies are tailored to reflect such risks. Insurance companies will, therefore, distinguish between people based on attributes such as gender, age and disability. Such distinctions may be justifiable, but some have raised questions and concerns in the community. The anti-discrimination laws permit these distinctions where the differential treatment is based on actuarial or statistical data upon which it is reasonable to rely. Where no such data is available, the differential treatment must be based upon other reputable medical advice or opinion.

1. Aims & Objectives

The EOC has received a number of inquiries and complaints about

insurance practices, mainly on the refusal to provide insurance coverage, the practice of charging increased premiums on the ground of sex or disability and the exclusion of coverage in respect of pre-existing conditions.[1]

In May 2000, the EOC commissioned a research study on insurance issues (EOC study). The aims of the study were to assist the EOC to understand:

- the impact of equal opportunities legislation on the provision of insurance generally;

- how insurance cover is provided by employers and insurance underwriters overseas with regard to anti-discrimination legislation;

- how such overseas insurance cover compares with insurance cover provided in Hong Kong; and

- whether anti-discrimination legislation overseas has affected the insurance policies offered and what changes, if any, employers and insurance underwriters have been required to make.

The overall purpose of the study was to assess whether the provision of insurance by employers and insurance companies in Hong Kong is in compliance with the anti-discrimination laws. Research has identified those issues and insurance practices that may lead to discrimination and unlawful acts under the legislation. Some are peculiar to Hong Kong; others were found to be common locally and overseas.

The study has led us to formulate a series of topics and questions for discussion, with the objective of promoting dialogue in the community

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[1] As at 30 November 2002, the EOC had received 19 complaints in relation to insurance (4 under SDO, 15 under DDO) and 138 enquires in relation to insurance (36 under SDO, 95 under DDO and 7 under FSDO).

and examining options and alternatives to current practices. We understand that the Hong Kong Federation of Insurers (HKFI) has already created a specialist Task Force to work closely with the EOC and other interest groups, and will be updating the insurance industry's Statement of Best Practice on Disability Discrimination. We encourage discussion and input from experts, regulators, the insurance industry, employers and consumers alike.

The responses to this Discussion Paper will inform a set of Insurance Guidelines which are intended to be published for consultation in 2003. Comments and views on all aspects of this Paper are sought, and in particular in respect of those parts of the Paper that are highlighted. Parties should send their comments and views to the Equal Opportunities Commission, 20th Floor, Office Tower, 1 Harbour Road, Wanchai for the attention of the Policy Support and Research Unit by 20 March 2003.

2. The Statutory Provisions

There are presently three pieces of anti-discrimination legislation in Hong Kong. These are the:

(i) Sex Discrimination Ordinance, Cap. 480 (SDO);

(ii) Disability Discrimination Ordinance, Cap. 487 (DDO);

(iii) Family Status Discrimination Ordinance, Cap. 527 (FSDO).

Under the SDO, it is unlawful to discriminate on the grounds of sex, marital status and pregnancy. Under the DDO it is unlawful to discriminate on the ground of disability and under the FSDO it is unlawful to discriminate on the ground of family status.

Each Ordinance makes discrimination on the given grounds unlawful in certain fields (or areas of public life). The relevant fields for the purposes of this Discussion Paper are the fields of employment and the provision of goods, facilities and services.

In the field of employment, it is unlawful for an employer to discriminate against a prospective or existing employee, on one or more of the given grounds, in terms of the benefits the employer provides to such person.[2]

In the field of the provision of goods, facilities and services, it is unlawful for the provider of same to discriminate against a person, on one or more of the given grounds, by refusing to provide any goods, facilities or services, in the terms or conditions upon which the goods, facilities or services are provided, or in the manner in which they are provided.[3]

The legislation defines "facilities" as including the provision of insurance.[4]

A defence is provided to employers and insurers who impose differential treatment on one or more of the given grounds. The defence permits differential treatment where it can be supported by reasonable statistical or actuarial data or medical advice or opinion, upon which it is reasonable to rely[5].

An additional defence is provided under the DDO, whereby providers of goods, facilities or services may claim unjustifiable hardship in respect of the provision of insurance.[6]

The specific inclusion of insurance in the provisions in the legislation indicates an intention on the part of the Government to ensure that insurance is provided to persons without regard to discriminatory factors, and that such persons should not be denied insurance, or treated less

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2 Sections 11 SDO & DDO; section 8 FSDO.

3 Section 28(1) SDO; section 26(1) DDO; section 19(1) FSDO.

4 Section 28(2) SDO, section 27 DDO; section 19(2) FSDO.

5 Section 51 SDO; section 52 DDO; section 38 FSDO.

6 Section 26(2) DDO.

favourably or adversely affected in the provision of insurance, unless such treatment can be justified or defended under the law.

3. The Meaning of Discrimination

There are two types of discrimination prohibited under the law: direct and indirect.

Direct discrimination occurs when a person is treated less favourably than another person, on one or more of the prohibited grounds.[7] Basically, this type of discrimination occurs when the person would not have received such treatment, but for their sex, pregnancy, marital status, disability or family status. For example, a single mother is denied insurance but, had she been a single woman without a child or a married woman in the same circumstances, she would have been treated more favourably. Once the causal link between the treatment and the given ground has been established, the reasons for the directly discriminatory action or policy for it are not relevant. Reasonableness is not a defence to direct discrimination. The only defences to direct discrimination are those specified in the legislation itself, as interpreted by courts and tribunals.

Indirect discrimination occurs when a requirement or condition is imposed on all persons, regardless of sex, pregnancy, marital status, disability or family status, but which has an adverse proportional effect on persons with the given attribute, the individual with the given attribute cannot comply with such condition or requirement, and the condition or requirement is not justifiable.[8] For example, an insurance company gives a discount to persons who have existing car insurance policies with the company. Customers with a disability who are eligible to obtain the discount may be proportionality smaller in number than those who do not have a disability and can fulfill the requirement.

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[7] Section 5(1)(a) SDO; section 6(a) DDO; section 5(a) FSDO.

[8] Section 5(1)(b) SDO; section 6(b) DDO; section 5(b) FSDO.

If the indirectly discriminatory actions or practices can be shown to be justifiable, they are not unlawful under the legislation.

4. Application of the Law

The non-employment related provisions of the SDO and the DDO became operational on 20 September 1996. Since that date, it has been unlawful for insurance providers to discriminate on the ground of sex, pregnancy, marital status and disability in the field of the provision of goods, services and facilities.

The employment related provisions of the SDO and the DDO became operational on 20 December 1996. Since that date, it has been unlawful for employers and insurers to discriminate on the grounds of sex, pregnancy, marital status and disability in the field of employment.

The FSDO became operational on 21 November 1997. Since that date, it has been unlawful for employers and insurers to discriminate on the ground of family status in the fields of employment and the provision of goods, services and facilities.

Although the legislation does not operate retrospectively, it is important for insurers and employers to note that discrimination in insurance happens at the time the discriminatory act or conduct takes place. This is not necessarily the same time as the contract was entered into. It depends on the circumstances in each case. Thus, if a contract for medical insurance cover was entered into in 1990, and it contained a pre-existing condition exclusion clause, the refusal of a claim in 1999 on the basis of that exclusion clause would be covered by the DDO.

The only exception to this relates to discrimination on the ground of sex, in respect of provision in relation to death or retirement benefits, where the policy was entered into before 15 October 1997 and continues thereafter, provided that such provision in relation to retirement does not discriminate against a woman in terms of employment promotion, transfer, training, dismissal, demotion or any detriment resulting in

dismissal or involving demotion.[9]

B. UNLAWFUL DISCRIMINATION

5. Discrimination on the Ground of Disability

"Disability" is widely defined in the DDO.[10] It includes:

- total or partial loss of bodily or mental functions
- total or partial loss of body
- the presence of organisms causing, or capable of causing, disease or illness
- the malfunction, malformation or disfigurement of a part of body
- a disorder or malfunction that results in learning differently from a person without the disorder or malfunction
- a disorder, illness or disease affecting thought process, perception of reality, emotions or judgment or resulting in disturbed behaviour.

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[9] Sections 11(4), 15(4) and 16(4) SDO.

[10] Section 2(1) DDO.

It also includes a disability that:

- presently exists
- previously existed but no longer exists
- may exist in the future
- is imputed

Disability discrimination is commonly found in accident, medical, health and life insurance, but may also occur in car and travel insurance.

i) Exclusion of Pre-existing Conditions

Exclusion clauses are sometimes a useful way of offering an insurance policy to a person with a disability, without denying him or her cover but reducing the risk. This applies where the person has a pre-existing condition or is susceptible to developing a particular condition, which is likely to lead to a claim under the policy. It is recognised that the lack of such an exclusion may result in increased premiums, which could make the coverage unaffordable for such persons, but the use of exclusion clauses nevertheless raises concern.

Although there is no common definition of what is meant by a pre-existing condition, many insurers claim that a pre-existing condition is one that existed at any time before the inception of a policy. Others take the view that a pre-existing condition is one that exists at claim time and pre-existed at the inception of the insurance contract[11].

The term basically covers all conditions that a person is suffering from, be it congenital or acquired and regardless if the insured person is aware of them or not, before the policy becomes effective. This seems

[11] The latter view is that of the Insurance Ombudsman in the U.K., who does not agree with the former view unless the insurance contract contains a specific clause to that effect.

particularly onerous on the consumer and complexities and problems may arise as to when a pre-existing condition might become known to an individual but is not diagnosed.

Judicial authority in the U.K. has held that pre-existing conditions must have both existed and been diagnosed at the time of application for the policy, in order for them to be classed as pre-existing.[12]

In the U.K., insurance companies typically exclude pre-existing conditions that have occurred in the five years prior to the policy being taken out, and will not pay for medical claims arising from those conditions for the two years following inception of the policy.

Similarly, in the U.S.A., insurance companies will also exclude pre-existing conditions, but the position there is affected by various state laws. State laws may require policies to have shorter pre-existing condition exclusion periods, and certain states may not permit pre-existing condition exclusions in certain cases. For example, where there is transfer from one cover to another under a "guaranteed issue", and someone is locked into an insurer and cannot afford to change because of an established condition that is covered by the present insurer, but would be excluded as a pre-existing condition by a new insurer[13].

The position in the U.S.A. is further affected by the Health Insurance Portability and Accountability Act 1996 (HIPAA), which provides for portability of insurance when an employee moves from one employer to another. However, a plan may exclude coverage of a new customer's pre-existing medical condition if medical advice or treatment was recommended or received within six months prior to enrolment, but plans may not have a pre-existing condition exclusion period longer than 12-18 months, depending on the employment status of the employee. Furthermore, a pre-existing condition exclusion may not be applied to

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12 Cook v Financial Insurance Co. Ltd [1998] 1 WLR 1765

13 Texas Department of Insurance; see http://www.tdi.state.tx.us/commish/b-0043-9.html

pregnancy or to a newborn or adopted child under 18 years, and group health plans with pre-existing condition exclusions must reduce the length of the exclusion period by the amount of time an individual had prior coverage.

In Hong Kong, the exclusion of pre-existing conditions is common in both group and individual medical plans. Insurance application forms will often contain clauses such as:

> *"Within the last seven years has any proposed insured person any illnesses / disease, such as asthma, cancer, diabetics, heart disease, kidney disease, liver disease, respiratory disorder, thyroid gland disease or ulcer. Within the last seven years has any proposed insured person had any condition, injury or physical impairment requiring consultation with a medical practitioner, laboratory test, regular medication, operation, in-patient treatment or x-ray imaging test ECG?"*

Insurance policies will often contain clauses such as:

> *"Benefits will not be paid for any direct or indirect treatment arising from existing illnesses or injury that originated prior to the entry date to the scheme unless these are fully disclosed in the application form and accepted by the company on entry to the scheme."*

The EOC accepts that insurance companies are entitled to exclude certain conditions in order to ensure business profitability and continuing viability. Insurance is, after all, the identification and classification of risk. If an insurer could not exclude a pre-existing condition, a person could theoretically insure themselves for the condition after it has occurred. Insurance relies on principle of fortuity; that is to say, the loss must be reasonably unexpected or uncertain.

In the course of the EOC study, however, it was observed that many exclusions are simply based on industry practice, and there is no correlation between the disability and the pre-existing condition.

Issues also arise as to whether a previously cured disease that does not recur can be considered as high risk. For example, the EOC study found that, in Indiana in the U.S.A. in 1996, an insurance company refused to pay a claim for surgery to deal with reflux oesophagitis. This decision was based on the fact that the insured had had the same condition in 1990, though surgery had successfully corrected it. Medical evidence from the insured said the condition was not "pre-existing", and likened it to a person breaking the same leg twice over a course of several years. It was only with the intervention of the Indiana Department of Insurance that the claim was settled.

It is arguable whether excluding pre-existing conditions amounts to less favourable treatment on the ground of disability or not. One argument is that exclusion clauses do not distinguish between people with disability and people without, but that they distinguish between people whose disability has manifested itself before the commencement of the insurance cover and those whose disability manifests itself subsequently. But this argument may ultimately not be a tenable one, given the wide definition of disability in the DDO and the language of the legislation.

Although the provisions have not yet been tested in court, the EOC adopts the view that an insurance company will not run foul of the legislation if the decision to exclude a particular pre-existing condition is referable to actuarial or other data from a source on which it is reasonable to rely, and the decision itself is reasonable having regard to the data and any other relevant factors.

The HKFI has undertaken to review and revise its Statement of Best Practice on Disability Discrimination in conjunction with the EOC.

ii) Blanket Exclusions

In New Zealand, insurance companies are permitted to make blanket exclusions of certain disabilities, provided that such decisions are based on actuarial data. This is important, as in New Zealand there is no right to refuse insurance cover and without such exclusions many areas of insurance would not be commercially viable. For insurance companies

in New Zealand, being forced to insure creates problems for insurers who would prefer not to have to underwrite some cover in some areas, rather than deal with complex risks.

Blanket exclusions are also common in other overseas countries included in the EOC study. In Australia, they are particularly common for self-inflicted conditions where individuals take out their own cover. In Canada, they are usually for a time limited period only.

Clearly, an insurer cannot – and should not – be compelled to provide insurance in respect of risks that are not profitable or are of an unknown nature. For example, in Hong Kong, blanket exclusions in respect of the following are common and would be considered reasonable in all the circumstances.

- abuse of drugs or alcohol;
- self-inflicted injuries or attempted suicide;
- injury or disease resulting from voluntary participation in criminal acts.

However, blanket exclusions in respect of the following, which are also common in Hong Kong, might not be considered reasonable unless the individual circumstances are taken into account –

- mental illness;
- HIV / AIDS;
- illnesses arising out of pregnancy.

In respect of illnesses arising out of pregnancy, insurers should note that a blanket exclusion in respect of this treatment could amount to discrimination on the ground of sex and / or pregnancy in certain circumstances. For example, a woman who contracts a virus following a caesarian section could claim unlawful discrimination if a virus

contracted after non-pregnancy related surgery is covered, but not the virus she contracted, on the basis that hers is excluded because it arose out of pregnancy.

It is also industry practice in Hong Kong for travel insurance policies to have blanket exclusions regarding pregnancy and disability. The justification for this is that insurers consider pregnancy controllable, and therefore not relevant for insurance cover, and that women who are pregnant and persons with a disability are at high risk and should not travel anyway. Such exclusions are also found in overseas travel insurance.

Clearly medical cover provided under travel policies differs from general medical policies, in that the period of cover is short term and so the increasing frequency and costs of claims cannot be predicted. However, it is of concern that pregnancy and disability may be excluded outright without any credible justification.

In the course of the EOC study, the researchers found that, in the U.K., the Insurance Ombudsman had expressed concern about the rigidity of travel insurance policies offered. He encouraged the industry to provide greater choice on the level of medical cover, although he does say that no policy should cover an individual traveling against medical advice.[14]

As has already been stated, the EOC accepts that insurance companies are entitled to exclude certain conditions in order to ensure profitability and continuing viability. Insurers cannot be compelled to insure bad risks. However, it is also not reasonable to use blanket exclusions to limit liability where it may be possible to provide the cover, but say at a reduced amount or by increasing the premium. Insurers should rely on actuarial or other data from a reasonable source in making blanket exclusions, and the decisions themselves should be reasonable taking all factors into account.

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[14] see http://www.theiob.org.uk/press/speeches/travel.html

The HKFI has agreed to review its usage of, the justification for, and the relevancy of pre-existing and blanket exclusion clauses as the highest priority in response to this paper. The HKFI also agrees that, when considering the insurance application of a person with mental disability, an underwriter must assess the severity of the disability of the proposed insured in order to determine whether or not the applicant is capable of entering into a legal contract.

With regard to HIV/AIDS, the HKFI considers that the approach proposed under the Pre-Existing Condition Section should prevail, given the nature of the risk presented. With regard to pregnancy related exclusions, the HKFI has undertaken to review the lack of cover for illnesses that are normally covered but are excluded when the insured is pregnant.

iii) Genetic Testing

The situation relating to genetic testing is a complex one. In Hong Kong at present, insurance companies do not ask for genetic tests to be carried out. It is, however, an area where technology is growing rapidly. Individuals themselves may wish to know in advance whether they have genetic disorders, particularly if they wish to take preventative measures to treat the condition to prevent possible development in the normal course of events.

The complexity of the issue is heightened by the fact that genetic conditions or disorders in many cases simply involve a pre-disposition to acquire a medical condition. In some instances, such as where the gene for Huntingdon's disease is diagnosed, there is some certainty and the risk can be calculated. Yet, in other cases, the individual may never actually acquire the condition or the disorder, even though the gene exists. Since the definition of disability under the DDO covers not only disabilities which exist in the present, but also disabilities which may exist in the future, or a disability which is imputed to a person, this brings genetic and congenital predisposition within the ambit of the DDO.

The EOC is concerned that individuals could be targets because of their genes. In the USA, where genetic testing is more prevalent, the Department of Health and Human Services found in a survey of people in families with genetic disorders, 22% indicated they, or a member of their family, had been refused health insurance on the basis of their genetic information.[15]

Yet, in the field of life insurance, life insurers in the U.K. accept 95% of proposals on standard terms, notwithstanding the wide spectrum of relevant information already available to them on proposal forms regarding lifestyle and medical and family history.[16] This suggests that the practical impact of genetic tests may not be that great, given that insurers have for years been making assessments based on available data of certain genetic disorders found in family histories (e.g.: Huntingdon's disease).

It may be that it is simply too early to tell how genetic testing will impact on medical and life insurance cover in Hong Kong. In Canada, there is a "wait and see" approach. In the U.K., the Association of British Insurers has published a Code of Practice on Genetic Testing which prohibits both the use of genetic information for preferred life underwriting, and the use of information obtained as a consequence of one person's genetic test disclosure, in the computation of a related family member's premium.

In the U.S.A., insurance companies cannot ask customers to take genetic tests but may use genetic tests results if they are available. In some states, such as California, genetic testing is actually banned.[17]

In New Zealand, the Insurance Guidelines published by the New Zealand Human Rights Commission state that insurance companies can request

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15 see http://www.genome.gov/page.cfm?pageiD=10000879

16 see http://www.actuaries.org.uk/pr-rels/1999/cdd0726.html

17 This is also the case in countries such as Denmark, Norway and the Netherlands.

genetic information but cannot insist that applicants undergo tests. This reflects the practice followed by insurance companies presently in New Zealand, thereby allowing them to calculate premiums based on the results.

In May 2000, the HKFI issued a Code of Practice – Genetics Testing & Insurance based primarily on the code issued by the Association of British Insurers.

The EOC suggests that insurers in Hong Kong who wish to rely on genetic information should exercise care. Discriminatory decisions based on such information may be unlawful, unless reasonably based on actuarial or other data or justifiable under the DDO.

6. Discrimination on the Ground of Sex

Sex is often used as a criterion for distinction in insurance, usually based on broad-brushed group classifications referable to actuarial or statistical data.

In certain types of insurance business, the actuarial evidence is undisputed. For example, in life insurance, actuarial data reveals that men on average die at an earlier age than women. Insurers, therefore, have a shorter time to collect premium payments, so they will usually charge men a higher rate. However, under the defence provisions in the legislation, even though the decision to charge an increased premium is based on actuarial data, the decision itself may not be a reasonable one and, therefore, may be unlawful.

Differential risk assessments also exist in the area of motor insurance, where young men are commonly rated at higher premiums than women of the same age. Presumably, this is based on information that young men – more so than young women – drive high powered cars and / or have bad accident records. It is not the individual who is classified on his or her own merit. Instead, the broad brushed group classification is applied and not individual variances within the class.

There have been some attempts overseas to introduce unisex pricing (i.e.: one price, regardless of sex) in insurance, but there appears to have been little success despite the fact that unisex pricing is one clear method of eliminating potentially unlawful discrimination on the basis of sex.

Another area where there may be gender bias against women is in the way insurance companies exclude certain types of female-specific illnesses from medical and health cover. For example, in Hong Kong it is common to exclude treatment for anorexia from medical insurance. In the U.S.A., it is common to exclude all breast diseases.

It is also common in some jurisdictions to exclude, or to limit, certain types of gender-specific surgery. The EOC study found that, generally, in the U.S.A., there was evidence of widespread sex discrimination in the area of medical costs arising from female-specific surgery.[18]

The EOC considers that sex discrimination in medical costs re-imbursement, in health and life insurance, in the area of annuities or pensions, and in motor insurance and other insurance, is unlawful unless it falls within one of the exceptions in the SDO.

7. Discrimination on the Ground of Pregnancy

Pregnancy is often not covered in individual or group medical plans in Hong Kong. The insurance industry argues that pregnancy is not traditionally the type of uncertainty that insurers are willing to cover: conditions such as normal pregnancy are predictable and often controllable. Hence, pregnancy cover is not commercially viable.

However, whilst there is no requirement under the law that employers who provide medical insurance to employees must also provide cover for

[18] The University of Wisconsin Medical Center reported that studies conducted in the U.S.A. revealed that certain male-specific surgeries were re-imbursed on average at rates of 37-40% higher than female-specific surgeries. (e.g: the male specific procedure known as TURP, in which a surgeon removes part of the prostate, was valued higher than its female-specific counterpart, known as hysteroscopic endometrial ablation.

pregnancy, where medical insurance is provided to employees, and it extends to pregnancy, excluding any illness arising out of pregnancy may amount to unlawful discrimination in certain cases.[19]

Similarly, in the area of travel insurance, it may amount to unlawful discrimination on the ground of pregnancy if insurers insert limitations or exclusions in respect of pregnancy or pregnancy-related conditions, unless such treatment is based on one of the defences set out in the SDO.

8. Discrimination on the Ground of Family Status

"Family status" is defined in the FSDO as the status of having responsibility for the care of an immediate family member.[20]

"Immediate family member" is defined in the FSDO as a person who is related by blood, marriage, adoption or affinity.[21]

The FSDO provides that direct discrimination exists not only when a person with family status is treated less favourably than a person without family status, but also where a person with a particular family status is treated less favourably than a person with family status – but without that particular family status.[22]

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[19] In the U.S.A., the Pregnancy Discrimination Act says that "Women affected by pregnancy or related conditions must be treated in the same manner as other applicants or employees with similar abilities or limitations." The law does not make medical cover mandatory, but if provided it must not discriminate.

[20] Section 2 FSDO.

[21] Ibid.

[22] Section 5 FSDO.

In other words, direct discrimination may occur not only when an employer treats an employee with a child less favourably than an employee without a child, but also when an employer treats an employee with a child less favourably than an employee with, say, an elderly parent.

The definition of family status discrimination and the broad definition of immediate family member in the FSDO are rather unique, in that there is no similar comparison found in overseas jurisdictions.

In April 1998 the EOC advised the Government that, on the proper construction on section 5 of the FSDO, the restriction of medical benefits by employers to immediate family members comprising only spouses and children of a limited age could amount to unlawful discrimination. As a result, in June 2000 the Government amended the FSDO by making it lawful for employers and principals to limit direct or indirect access to benefits, facilities or services to certain immediate family members.[23]

Such amendment, however, would not extend to insurers who might seek to discriminate on the ground of family status. For example, where a policy covers a natural child but not an adopted child.

There is also some concern that medical policies which exclude children of a certain age, for whom the policy-holder has responsibility for care, may be unlawfully discriminatory under the FSDO. For example, a father has responsibility for the care of his four children, all immediate family members. The oldest child is 23 years old, a student and dependant on the father. The father may claim discrimination on the ground of his particular family status, if the medical insurance excludes his 23 year old child from coverage.

This type of exclusion clause is a common one in medical policies. It is difficult to say how a court in Hong Kong would find, as the issue has not been litigated. However, in Canada, the Federal Court of Canada ruled that the Unemployment Insurance Act (know called the Employment

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[23] Family Status Discrimination (Amendment) Ordinance 2000.

Insurance Act) was discriminatory and contrary to the Canadian Human Rights Act, in that one of its provisions limited certain benefits to parents according to the age of the children. The Federal Court held that there was no rational link between the age of the child and the health of the child. Accordingly, it was found that the section constituted a discriminatory practice based on family status and contravened the Canadian Human Rights Act.[24]

9. Requests for Information

In general terms, insurance companies may ask whatever questions they like on proposal forms, and request whatever information they like from applicants, as the questions and requests are not of themselves discriminatory.[25] It is the use of such information to make decisions which are discriminatory, or to effect discriminatory treatment, which is unlawful.

In Hong Kong, the DDO states that it is unlawful for a person to request or require another to provide information, whether by completing a form or otherwise, that persons without a disability would not be requested or required to provide, for the purpose of committing an unlawful act under the legislation.[26]

Similarly, the DDO states that it is unlawful for prospective employers to request or require information of a medical nature, whether by completing a form or otherwise, in connection with discriminating against a prospective employee.[27] The only exception to this is where the prospective employer requires the medical information to determine

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[24] See http://www.chrc-ccdp.ca/news-comm/1997/jun19.asp

[25] All requests for personal data must also comply with the provisions of the Personal Data (Privacy) Ordinance.

[26] Section 42(1) DDO.

[27] Section 42(2) DDO.

whether the applicant would be able to perform the inherent requirements of the job or would require services or facilities not required by persons without a disability.[28]

However, although it is not unlawful in and of itself to ask for information, or to ask questions, employers, insurers and agents thereof should ensure that only relevant questions are asked and only relevant information is requested. Very broad questions or requests for information which appears irrelevant or based on stereotypical assumptions may lead to an inference that the purpose of the question or request is to unlawfully discriminate.

10. Refusal of Insurance, Increased Premiums & Limited Cover

Given that the business of insurance is the calculation of risk, and that some risks are acceptable whilst others are not, it is difficult to categorically state that every person has the right to be insured. Yet, this has not prevented discussion overseas about what is considered a real problem for persons (legally) rejected as uninsurable.

In the U.K., the Institute of Actuaries, in discussing the availability of general lines insurance, has queried *whether the availability of relevant insurance cover should be regarded as so important a human right, and so important a feature of an orderly society, as to require that arrangements be made to ensure that at least some minimum level of cover will always be obtainable at what may be regarded as a reasonable and affordable price.* The Institute reports some research that suggested that with a few exceptions it was in the interests of society for affordable cover to be provided.[29]

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[28] Section 42(3) DDO.

[29] see http://www.actuaries.org.uk/library/gn08.html

In Texas, several health benefit options have been created in order to provide coverage to persons with a disability who might otherwise be rejected. For example, the Texas Health Insurance Risk Pool sells insurance policies to consumers who were previously considered uninsurable, albeit at increased premiums of 200 per cent the standard rates.

In New Zealand, insurers may not refuse insurance outright. They may, however, use exclusion clauses or adjust policies according to the nature and existence of a particular condition, as long as such treatment is effected by reference to actuarial or other data.

In Australia, outright refusal of insurance is lawful, provided it can be justified on the basis of actuarial or other data, and the decision to discriminate is reasonable.

The position in Hong Kong is similar to that in Australia, in that refusal of insurance is not unlawful under the anti-discrimination legislation provided the decision to refuse falls within one of the statutory defences.

It is important for insurers to note that, outright refusal to insure may contravene the anti-discrimination laws in circumstances where other more appropriate or reasonable options exist. For example, providing the insurance cover at an increased premium, at a reduced amount (i.e.: limited cover) or with appropriate exclusion clauses.

The EOC survey found that, in Canada, it is more usual for companies to charge a higher premium than to reduce the level of cover. In New Zealand, Australia and the U.S.A., companies do both. Similarly, there is a practice in Hong Kong for insurers to charge a higher premium and to reduce the level of cover, depending on the circumstances.

Insurance which is provided on modified terms, such as with limited cover or at an increased premium, must also be provided in accordance with the anti-discrimination legislation. That means that the decision to charge an increased premium or to provide limited cover must of itself be justifiable under the legislation and based on actuarial or other data on which it is reasonable to rely, and reasonable in all the circumstances.

11. Deferral of Approval

Delays in providing insurance cover may result in hardship or detriment to certain applicants, particularly in respect of disability, and may lead to allegations of discrimination. Certainly it would amount to unlawful discrimination under the anti-discrimination legislation if deferral of approval in insurance were used as an excuse to refuse insurance.

However, since insurance is the calculation of risk, where the risk cannot be quantified or calculated at the time the application is made, it may not amount to unlawful discrimination to defer the risk to a later time when it is more likely that the risk can be quantified. For example, where an applicant has been diagnosed with a condition, but is still undergoing tests to determine its severity, it would be reasonable to defer approval of the application until a definite prognosis has been given. Outright refusal of insurance in such circumstances may amount to unlawful discrimination.

C. STATUTORY DEFENCES

The law in Hong Kong provides that –

> *"Nothing …… shall render unlawful the treatment of a person in relation to any class of insurance business, or similar matter involving the assessment of risk, where the treatment –*
>
> *(a) was effected by reference to actuarial or other data from a*

source on which it was reasonable to rely; and

(b) was reasonable having regard to the data and any other relevant factors"[30]

This defence applies in both the context of employment and the provision of goods, services and facilities.

Under the DDO, there is an additional defence available to providers of goods, services and facilities where –

"(a) the provisions of the goods, services or facilities would impose unjustifiable hardship on the person who would have to provide those goods, services or facilities;"[31]

12. Actuarial Data

The use of actuarial data is a crucial issue in determining whether differentiation in terms, rates and treatment between persons seeking insurance amounts to unlawful discrimination or is merely prudent underwriting.

Actuarial data includes mortality tables and probability tables dealing with death, accidents sickness, fires, industrial losses and natural disasters. Actuarial tables and data are used to determine the rates for various types of insurance and form the basis for many underwriting practices. The underlying assumption in actuarial science is that the frequency of past events may be used to predict or measure the probability of their future occurrence.

Actuarial data provides a legally accepted reason for differentiation between persons in the provision of insurance, not only in Hong Kong but

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[30] Sections 51 SDO, 52 DDO and 38 FSDO.

[31] Section 26(2) DDO.

also in other countries overseas such as New Zealand and Australia. At the same time, however, actuarial data is an easily-cited reason for insurers to discriminate and refuse or limit cover, increase premiums, provide exclusion clauses and / or otherwise modify policies. For this reason, the anti-discrimination laws not only require that the actuarial data derive from a reasonable source, but that the discriminatory decision itself be reasonable in all the circumstances.

In one overseas study, it is stated that "A closer look at the actual practice reveals that underwriting decisions are rarely made using a statistically sound mathematical methodology."[32] Furthermore, the same study found that actuarial evidence was itself used selectively, in that women paid less in life insurance, but until recently their rates commonly were based on a three-year setback from men's tables when the actual gap in life expectancy was six to nine years. At the same time, annuities, for which women were paid more, reflected the full gap in life expectancy.

Similarly, in respect of motor insurance classifications, the fairness of group averages in actuarial data was found to be affected by the consistency of claims across a group. For example, a group half of whose members have losses of $90 and half of whom have losses of $10 will have a group average loss of $50, as will a group half of whose members have losses of $45 and the other half losses of $55. The latter group is far more homogeneous and someone in the group rated according to a historical expectation of a $50 loss would be receiving a fairer assessment than someone from the first group.[33]

Actuarial practice has its limitations. A classification is only valid as a basis for deciding premium levels if it, in aggregate figures, actually predicts future loss. Where classifications cannot adequately predict future loss, they should not be used as a basis for decision-making.

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[32] see http://www.law.indiana.edu/ilj/v72/no1/morrison.html

[33] Ibid. Wortham reported on studies by two States, Massachusetts and New Jersey, which concluded that classifications create groups that are relatively homogeneous rather than heterogeneous and that this should raise a concern of unfair discrimination.

Reliance on actuarial data does not provide automatic exemption from the provisions of the law. Even with neutral risk assessment based on actuarial data, the relevance of the data to the time and place of the underwriting is a relevant consideration in assessing appropriate treatment.

For example, data that is out of date will not indicate present risk levels accurately. Actuarial tables in the UK, which prior to 1999 predicted that a woman who was 35 years old in 1999 could expect to live until she was 84 years and seven months, are now out of date. In 1999, the same woman was expected to live until she was 88 years and one month. Furthermore, the average 35 year old insured male in the UK in 1999 was expected to live five years longer than had been earlier predicted, and the gap in life expectancy between men and women is fast closing.[34] This has obvious implications in respect of life insurance and annuities for men and women, and the degree to which sex discrimination is relevant.

In Hong Kong, insurers underwriting life insurance rely on both local and overseas data and the EOC study found that the quality and use of actuarial data in Hong Kong in this field is well developed. This highlights the need to ensure that the actuarial data is accurate and up to date, but also relevant. For example, data that applies to one country or one geopolitical area within a country may not accurately reflect the risks in another, particularly in certain areas of insurance business.[35]

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[34] Continuous Mortality Investigation Bureau, UK; see http://www.actuaries.org.uk/pr-rels/1999/cmibr17.html

[35] The Institute of Actuaries in the UK says, when dealing with "post-retirement medical care for acute medical conditions…. When valuing overseas arrangements, it should be expected that costs and utilisation statistics from the United Kingdom will not be appropriate. See: www.actuaries.org.uk/library/gn21.html

Decisions based on actuarial data which is not from a source on which is reasonable to rely, and which is not accurate and relevant to the time and place of underwriting, may not be considered reasonable in all the circumstances, and may not meet the criteria of the statutory defences relating to actuarial data.

13. Other data

The statutory defences relating to data talk in terms of "actuarial data" and "other data". The expression "other data" is not defined, but would presumably include all non-actuarial data, provided it comes from a reasonable source and provided that the decision based upon it is reasonable having regard to the data itself and all other factors. Clearly, it will depend on the facts in each case to determine the appropriateness of the "other data" relied on.

Sources of data may include:

(i) Underwriting Manuals

(ii) Local Data / Research Studies / Statistics

(iii) Overseas Data / Research Studies / Statistics

(iv) Domestic and International Claims Experience

(v) Medical and Professional Opinion

(vi) Actuarial Advice or Opinion

(i) Underwriting Manuals

These are large documents that have generally been compiled by insurance or reinsurance companies, and include detailed information about the nature and degree of risk associated with insuring people and

objects under a wide variety of conditions. They may also be based on actuarial or statistical data, medical opinion, and the like.

Provided that they are based on accurate data and opinion, are updated to take into account the latest advances in medicine, adaptive technology or other areas / matters affecting the level of risk or loss, and are relevant to the time and place of the underwriting decision, underwriting manuals may be considered other data from a source on which it is reasonable to rely.

(ii) Local Data / Research Studies / Statistics

Some actuarial data includes relevant domestic population or research studies that use specific data or statistics gathered from a range of reliable sources, both about events and people. This may include census statistics, research studies reported in major medical journals and studies produced by the actuaries' institutes.

Such data may fulfil the criteria set out in the statutory defences, provided it is relevant, accurate and up to date and the decision based upon it is reasonable in all the circumstances. This will depend on the individual circumstances in each case, including whether there is competing, contradictory or more credible data available.

(iii) Overseas Data / Research Studies / Statistics

Where local data of this type is unavailable or insufficient, insurance companies often rely on international population or medical studies or statistics which may or may not be modified for local conditions. Although such data may derive from reliable sources, it is necessary to ensure that it is relevant to local conditions.

Overseas conditions and arrangements may not be appropriate and should not even be relied on to provide a base unless inadequate data exists locally. Again, such data should be relevant, accurate and up to date and the decision based upon it should be reasonable in all the circumstances.

(iv) Domestic and International Claims Experience

Specific insurance claims data may be regarded as providing a reasonable basis for the setting of premiums, but there are many variables that need to be taken into account. These include the fact that the industry does not always share commercially sensitive information.

Beginning in 1998, the Medical Insurance Association under the HKFI began commissioning independent professional consultants to conduct annual medical claims statistics among member companies. Not only can member companies obtain the comprehensive data of all participants, the medical claims data are also compiled in a simplified booklet which is made available to the public on an annual basis.

The HKFI has advised that, in the longer term, it may consider the development of exchanging claims data on a wide variety of lines of business, but that such an exchange will not be possible without overcoming hurdles in the Personal Data (Privacy) Ordinance.

The EOC takes the view that claims experience and medical claims data could fulfil the criteria set out in the statutory defences, but only where such collection of data is comprehensive, its scope is reasonable, it is credible and it provides a reasonable basis upon which an underwriting decision is made.

(v) Medical and Professional Opinion

Insurance companies will often rely on medical opinion, or other professional opinion (such as occupational therapists, physiotherapists, clinical psychologists, and the like), when dealing with medical matters.

This may be appropriate in certain individual cases, particularly where a specialist opinion is required to advise on the risk or where no other data is available in respect of the particular condition or disability.

Medical and professional opinion may fulfil the criteria set out in the statutory defences, provided it is relevant, credible and the professional's

knowledge is expert and up to date. Whether the decision based on such data is reasonable in all the circumstances will depend on the individual facts in each case, including whether there is a competing or contradictory opinion, or more credible data, available.

(vi) Actuarial Advice or Opinion

Insurers will also use actuarial advice or opinion to assist quantifying risk when there is no other data available and the opinion is from a relevant and reliable source. For example, actuarial opinion may be helpful making allowances for differences in degree of disability between an individual applying for insurance and the study population.

However, the use of actuarial advice or opinion could be fraught with danger, given that actuaries have been known to give conflicting advice when giving evidence for opposing parties in legal disputes.[36] Such advice may nevertheless be acceptable as actuaries, like many other professionals known to give different opinions, are well placed to give advice because of their training and understanding of the relationships between the policy conditions, pricing and reserving. As long as such advice or opinion meets the criteria in the statutory offences, it may be relied upon. The EOC has been advised that the Actuarial Society of Hong Kong would be prepared to issue a Guidance Note, in conjunction with the EOC, which outlines actuaries' responsibilities under the anti-discrimination legislation.

14. Unjustifiable Hardship

"Unjustifiable hardship" is defined in the DDO as follows:-

> *"For the purposes of this Ordinance, in determining what constitutes unjustifiable hardship, all relevant circumstances of the particular case are to be taken into account including-*

[36] D. v A Registered Life Insurer [2000]. See http://law.agps.gov.au

(a) the reasonableness of any accommodation to be made available to a person with a disability;

(b) the nature of the benefit or detriment likely to accrue or be suffered by any persons concerned;

(c) the effect of the disability of a person concerned; and

(d) the financial circumstances of and the estimated amount of expenditure (including recurrent expenditure) required to be made by the person claiming unjustifiable hardship."[37]

This means that, in order for insurance providers to avail themselves of the defence in section 26(2) of the DDO, they must not only show that the provision of the requested insurance is not financially viable, commercially sound, or risk-worthy, they must all take into consideration the factors set out in section 4 of the DDO.

D. THE INSURANCE INDUSTRY IN HONG KONG

15. Regulation of the Industry

Hong Kong is one of the leading insurance centers in the world, providing general and long term insurance. Long term insurance business includes individual life, group life, endowment and retirement insurance. General insurance business includes accident, medical, health and property insurance and insurance business of a short-term nature. In 2000, the annual gross premium was close to HK$60 billion.

The insurance industry in Hong Kong is served by a huge intermediary force consisting of brokers and agents. At the end of October 2002,

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[37] Section 4 DDO.

there were 199 authorised insurers with 428 brokers and 3,364 technical representatives. There were 45,516 registered agents, including corporate, individual and technical representatives. There are no statistics on the business distribution between brokers and agents, though most employee compensation business is written through the brokers.

A 1998 survey conducted by the Census & Statistics Department found that 2.68 million persons in Hong Kong were entitled to medical benefits, representing a penetration rate of 40.2%. Among the 2.68 million, 1.62 million were entitled to medical benefits from employers, 0.65 million were covered by medical insurance, and the remaining 0.41 million enjoyed both kinds of medical protection. However, some 3.98 million of the then population were not covered by medical benefits and the lack of medical coverage for women and the aged was apparent.[38]

The Insurance Companies Ordinance (ICO) provides the regulatory framework for the supervision of insurers and insurance intermediaries in Hong Kong. Unlike many other countries overseas, Hong Kong's insurance industry is largely self-regulated. There is no Insurance Ombudsman, but there is a Commissioner of Insurance (the Commissioner) whose primary aim is to ensure financial viability in the industry and to foster self-regulation. The Commissioner ensures that there is compliance with the ICO and may issue a code of practice for insurance intermediaries.

[38] In this group, 3.23 million were aged 15 and over. In terms of activity status, 47.8% were economically active persons, 20.2% were retirees and 18.9% were homemakers. 98% of the homemakers were women.

The Commissioner, appointed as the Insurance Authority, does not have statutory power to intervene in commercial disputes among insurers, insurance intermediaries and policyholders. The Insurance Authority has a monitoring role, to ensure that complaints are properly handled in accordance with the rules and regulations within the self-regulatory framework. The Government considers that it would be in the interests of the insurance industry and the insuring public to maintain this simple and inexpensive avenue for resolving claims disputes.[39]

The HKFI is formed by insurers to promote insurance to the public, to build consumer confidence in the industry, and to encourage high standards of ethics and professionalism amongst its members. The Corporate Communications Unit of the HKFI is responsible for handling public enquiries, including complaints from the public for failing to obtain insurance best suited to their needs.

Hong Kong does not have an Insurance Ombudsman. The purpose of an Insurance Ombudsman in many overseas countries is to resolve disputes between insurers and consumers in an independent, impartial, cost-effective, efficient, informal and fair way. Often, the Ombudsman has power to make awards in favour of a complainant. In New Zealand, the Insurance Ombudsman is actually appointed and funded by the insurance industry.

The EOC study found that, in many of the countries overseas where similar anti-discrimination laws to Hong Kong applied, there was a considerable and growing interest in the prevention of unlawful discrimination and regulatory and human rights organizations had arisen to address this need. However, in Hong Kong, the impact of equal opportunities legislation appeared to be less.[40]

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[39] See 5/2000 issue of the 1-Lens, published by the Office of the Commissioner.

[40] The EOC survey looked at Australia, Canada, New Zealand, the U.K. and the U.S.A.

Furthermore, in the course of the EOC study, representatives of the HKFI stated that there were many foreign owned and operated insurance companies in Hong Kong, all of which had their own processes and procedures that had to comply with their foreign corporate requirements. The HKFI considered that this made the reaching of common agreement between parties in Hong Kong very difficult. Industry-wide changes to practices, therefore, tended to be slow and fragmented. HKFI members felt that the industry wanted to operate in as fair a manner as possible, provided this could be done without due escalation of costs or decrease in profitability.

Given the above considerations, the question that may be asked is whether the existing system of self-regulation of the industry is sufficient or adequate to deal with issues relating to discriminatory practices by insurance companies. Certainly the Corporate Communications Unit of the HKFI provides a mechanism for dealing with consumer enquiries and complaints. The EOC asks whether the appointment of an independent Insurance Ombudsman (whether appointed and / or funded by the insurance industry or not) is something that we should work towards in Hong Kong.

16. Views Sought

Views are also sought from all sectors in the community in respect of the contents of this Paper.

In particular, views are sought from Hong Kong's insurance industry in respect of the following issues:

- Fair and Non-discriminatory Practices

  How can insurance practices in Hong Kong be made more open and transparent, so that applicants may have more information about the insurance decision and the basis upon which it is made? The Code of Conduct for Insurers may be a useful educational tool. Training and exchange of views are effective means of sensitizing the industry on customer needs and rights in the underwriting and

marketing processes. How can the EOC co-operate and work with the industry to achieve this?

- Definition of Terms

The EOC encourages the industry to develop definitions for critical terms, such as what is meant by pre-existing conditions. These terms are made even more difficult because they are used in a variety of ways, and applied to widely differing circumstances. According to the ICCB 2000 Annual Report, more than 30% of the disputed cases reviewed in 2000 arose from the application of policy terms. As many terms in an insurance contract have very specific definitions, it is not surprising that policyholders apply broader references than construed in the policy. Agreement or consensus within the industry would help to resolve these issues more rapidly[41].

- Availability and Affordability

The EOC encourages the industry to look at means of enhancing and ensuring availability and affordability of insurance products to meet the changing needs of society. The aging population has social policy implications as well as market implications, in the kinds of medical, health and retirement products provided. The availability of products and affordability levels are interrelated and in turn affect the size of the insurance pool.

- Portability of Accumulated Qualifying Period

The EOC supports and encourages the introduction of legislation enabling insured persons to take their insurance coverage with them when they have one employer to go to another. This would avoid going through qualifying periods all over again, and they would not be subject to pre-existing conditions exclusions for conditions that

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[41] Insurance contracts referred to by the HKFI relate to insurances effected in Hong Kong by individual policyholders resident in Hong Kong and insured in their private capacity.

did not exist prior to the initial insurance coverage (but may have developed by the time they commenced the new employment). This portability of insurance protection is similar to what is practiced in the USA upon the introduction of the HIPAA and is already practiced in Hong Kong by a number of insurers.