
Human Rights Issues in Insurance

DISCUSSION PAPER

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ONTARIO HUMAN RIGHTS COMMISSION**

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HUMAN RIGHTS IN INSURANCE ISSUES

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HUMAN RIGHTS ISSUES IN INSURANCE

DISCUSSION PAPER

INTRODUCTION

As part of its mandate under the Ontario *Human Rights Code* to promote awareness and understanding of human rights, the Ontario Human Rights Commission has initiated a research project to examine human rights issues in the insurance industry.

The objective of the Paper is twofold: to promote dialogue on protecting human rights in the insurance industry and to examine alternatives to current practices by obtaining input from experts, regulators and consumers. Access to insurance in our society raises significant issues about distributive justice and fairness in the public sphere, issues that have received scant attention in Canada and in Ontario where rate setting has traditionally been viewed as a private matter.

In 1992, the Supreme Court of Canada in *Bates v. Zurich Insurance* encouraged the industry to begin looking more closely at non-discriminatory alternatives in rate setting in the auto industry. It ruled that the insurance industry could continue to use discriminatory criteria such as age and marital status as a *bona fide* means of assessing risk, but that the industry could not do so indefinitely.

In light of the Supreme Court of Canada's comments on this matter and the relative scarcity of human rights analysis on the insurance industry in this province, the Commission is of the view that this is an appropriate time to give consideration to human rights issues in insurance. This Discussion Paper provides a review of insurance-related legislative authority, provisions of the *Human Rights Code* (the "Code") and issues of discrimination in insurance. A summary of relevant *Code* sections, related legislation and selected case law are included in the Appendices.

INSURANCE INDUSTRY IN ONTARIO

The insurance industry in Ontario is regulated by the *Insurance Act* (R.S.O. 1990, c. I.8). The Ministry of Finance regulates insurance services through the Financial Services Commission of Ontario (FSCO), an amalgamation of the former Ontario Insurance Commission, the Pension Commission and the Deposit Institutions Division of the Ministry of Finance.

In his introduction to the *Study Paper on the Legal Aspects of Long-term Disability Insurance*, author Marvin Baer remarks, however, that "many of the basic laws and

principles that regulate insurance are found in the common law and the legislation tends to be of a piece-meal nature”¹.

Baer goes on to say that the insurance industry has no legal obligations directly relating to the assessment of risk. The "Unfair Practices" provision of the *Insurance Act* is the only legal deterrent and the Superintendent of Financial Services would not often take action under this provision.

However, FSCO points out that potentially unfair practices are routinely eliminated by agreement through negotiations conducted by FSCO staff in several departments. Hence holding formal hearings has not been necessary for the most part.

THE FINANCIAL SERVICES COMMISSION OF ONTARIO (FSCO)

As a regulator, FSCO does not have the authority to make regulatory or legislative changes, although FSCO may provide advice to the government in such matters.

FSCO's overall objective for insurance is to build public confidence in Ontario's insurance industry. It does this by:

- Licensing companies to meet Ontario's needs for all types of insurance;
- Monitoring the industry to protect the solvency of insurance companies incorporated in Ontario;
- Insisting on high standards of market conduct, including sound business practices and fair access for consumers;
- Taking disciplinary and enforcement measures when necessary; and,
- Providing unbiased consumer information.

FSCO includes a Tribunal to provide expert, prompt, and effective review of regulatory decisions. FSCO has an Advisory Council to provide FSCO with advice and recommendations on matters such as its priorities, fees and assessment structure. Members of the Advisory Council are participants in the insurance, pension, loan and trust, credit unions and *caisses populaires*, co-operatives and mortgage broker sectors, and include consumer representatives.

Improved measures are being put in place to help consumers get their insurance complaints resolved more quickly. Among them was the appointment at FSCO of the first Insurance Ombudsman in Canada. As well, a complaint handling protocol has been established for all insurance companies licensed to operate in Ontario. In addition, each company has an Ombudsman Liaison who oversees the complaint handling process. FSCO also has a technical working group called the Market Watch Committee - Property and Casualty Insurance, which focuses on identifying industry

¹ Baer, Marvin. "Study Paper on the Legal Aspects of Long-Term Disability Insurance" (1996) p.2, prepared for the Ontario Law Reform Commission and submitted to the Attorney General for Ontario.

issues and consumer needs, and will co-ordinate consumer information. Finally, FSCO has a Dispute Resolution Group (DRG), which hosts regular consultation forums with insurers and with members of the legal profession. FSCO is currently undertaking a major review of the regulation of insurance distribution.

Dispute Resolution Group

In June 1998 the Hon. George W. Adams, QC reported on his independent audit of FSCO's Dispute Resolution Group (DRG). He was asked to review its overall performance given the substantial changes to the DRG's legislative mandate over the previous eight years and the (then upcoming) merger of the Ontario Insurance Commission (OIC) into the new FSCO.

The aim of this review was to examine the strengths and weaknesses of the DRG; to identify obvious improvements that may be available to better attain its goals; and to identify areas in need of further study. The report commented on operational efficiency, standards of customer service, integrity of the system, fairness of the system, and the system's capacity to meet all regulatory and legislative requirements. Mr. Adams wrote:

"The Dispute Resolution Group at the Ontario Insurance Commission has been in existence since 1990. The DRG is a self-contained mediation, arbitration and appeals system with jurisdiction over personal injury automobile accident claims arising out of the three Statutory Accident Benefits Schedules (SABS). It is the largest, most comprehensive dispute resolution system of any Ontario administrative agency, board or commission. It is widely known to be a pioneer on the cutting edge of dispute resolution best practices."

INSURANCE-RELATED PROVISIONS OF THE CODE

There are six sections in the *Code* that have implications for the insurance industry (see Appendix). Section 3 prohibits discrimination in contracts, which would therefore prohibit discrimination in insurance contracts.

Section 5 prohibits discrimination in employment which would include employee benefit plans that relate to insurance.

Section 10 defines the term "group insurance" as a single contract of life insurance or life and disability insurance which insures a number of persons. The contract is between an insurer and an association, employer or other person.

Section 11 prohibits discrimination resulting from the use of a general rule or condition that, although applied to all individuals, might have an indirect or adverse impact on individuals identified by a prohibited ground.

Finally, there are four insurance-related defences (or exemptions) available to respondents under sections 22 and 25 of the *Code*. The Board of Inquiry in *Thornton*² accepted that the *Code* sets out the following hierarchy of defences, each with an increasing number of pre-conditions:

- Section 25(2) provides that employee pension or group insurance plans based on age, sex, marital status or family status do not offend the *Code* if they comply with the regulations under the *Employment Standards Act*.
- Section 22 provides that automobile; life; accident, sickness or disability insurance; group insurance; or life annuity policies, not part of an employment situation, may make distinctions based on age, sex, marital and family status, or handicap, but these distinctions must be made on reasonable and *bona fide* grounds.
- Section 25(3)(b) provides that group insurance plans for employee groups with fewer than 25 members may make distinctions based on disability, provided that the distinction is reasonable and *bona fide* and made on the ground of a pre-existing handicap.
- Section 25(3)(a) provides that other employee disability or life insurance contracts may make distinctions based on disability provided the distinction is reasonable and *bona fide* and based on a pre-existing handicap that substantially increases the risk.

HUMAN RIGHTS ISSUES IN INSURANCE

THE *BATES V. ZURICH* DECISION

To date, one of the most influential rulings relating to insurance and the *Code* has been the Supreme Court of Canada's majority ruling in *Bates v. Zurich*³ with respect to the "reasonable and *bona fide*" test under section 22 of the *Code* (section 21 at the time of the complaint). This ruling is binding on all lower courts and tribunals and Boards of Inquiry have also applied the section 22 test in cases dealing with employment under section 25 of the *Code*⁴.

The defence in section 22 of the *Code* allows insurance companies to make distinctions in individual insurance policies and (non-employment) group insurance policies based on age, sex, marital status, family status or handicap but only if those distinctions are made on reasonable and *bona fide* grounds.

² *Thornton v. North American Life Assurance Co. (No.5)* (1992), 17 C.H.R.R. D481 (Ont. B.O.I)

³ *Zurich Insurance Co. v. Ontario (Human Rights Comm.)* (1992), 16 C.H.R.R. D/255 (S.C.C.)

⁴ For example, *Thornton v. North American Life Assurance Company et al.*

At issue before the Court was whether Zurich Insurance discriminated against Michael Bates when they charged him higher premiums for automobile insurance because of his age, sex, and marital status.

The Majority Decision

The Court defined a practice as *bona fide* if it was adopted honestly, in the interests of sound and accepted business practice and not for the purpose of defeating the rights protected under the *Code*. It was not disputed that Zurich acted in good faith when setting its insurance premiums.

The judgement focused on the application of the "reasonableness" test to the facts of the case. The Court held that a discriminatory practice is "reasonable" if:

- (I) It is based on a sound and accepted insurance practice; and
- (II) There is no practical alternative.

In terms of the first part of the reasonableness test, a sound and accepted insurance practice was defined as one that is adopted "for the purpose of achieving the legitimate business objective of charging premiums that are commensurate with risk".

The majority of the Court found that Zurich's decision in setting the premiums was based on credible actuarial evidence available at the time of the complaint. That actuarial evidence consisted of a statistical correlation between age, sex and marital status and insurance losses which showed that young male drivers are involved in more accidents than other drivers.

The Court then considered whether a practical alternative existed at the time of the complaint. The Court found that, in 1983, there was no practical alternative for Zurich to setting premiums based on age, sex and marital status. The Court held it would be unreasonable to expect Zurich to guess at what level premiums should be set rather than relying on statistically valid, albeit discriminatory data.

The Court made it clear, however, that the insurance industry should not continue indefinitely to use discriminatory criteria for rate setting. The Court found that, according to the evidence, three years are required to obtain meaningful statistics. The Court also stated that "the industry must strive to avoid setting premiums based on enumerated grounds".

The Dissenting Judges

The two dissenting judges would have ruled in favour of the Commission. They made a number of persuasive arguments in keeping with a broad, liberal and purposive interpretation of human rights legislation:

- The respondents should not be allowed to justify discriminatory practices on the basis of tradition. Fifty years of discriminatory rate classification is not an excuse.
- A statistical correlation is not sufficient to justify the reasonableness of a discriminatory practice. There must be a causal connection.
- A reasonable alternative existed. Premiums for drivers over 25 years of age are set according to distance driven and accident history. There was no evidence that these criteria could not be used for drivers under 25 years of age.
- The absence of statistics on an alternative classification system does not establish that there is no alternative.

Implications

The Court's application of the reasonableness test reveals the majority's deference to established tradition of the insurance industry. Respondent insurance companies can easily argue that their practices are well established and accepted in the industry. This argument of tradition is not an accepted defence in other types of human rights complaints. And, one could argue that discriminatory attitudes and behaviours would not change if respondents could justify their actions based solely on tradition.

That being said, the Commission would have to consider the statistical evidence available to the insurance industry at the time of a complaint. However, as noted by the dissenting judges, simply because an insurance company does not have statistics developed for their own use does not mean that current, non-discriminatory statistics could not be made available.

The Court's comments regarding an available practical alternative imply that the insurance industry could have developed a new system for automobile insurance based on non-discriminatory criteria. To date, the industry has not developed a new system for automobile insurance. A similar automobile insurance complaint might now be decided quite differently. The Supreme Court clearly stated that the insurance industry should be actively working to develop non-discriminatory criteria for assessing risk. The existing discriminatory classification system may no longer meet the test of a sound and accepted insurance practice.

AUTO INSURANCE

The Section 22 defence in the *Code* includes auto insurance where distinctions may be made based on age, sex, marital and family status, or handicap, but these distinctions must be made on reasonable and *bona fide* grounds.

Presently in Ontario, auto insurance risk assessment is in part based on family groupings, age and sex. As a result complaints of discrimination on the grounds of marital status, family status, age and sex are likely to continue.

A variety of scenarios based on marital or family status can appear to result in discriminatory treatment. For example, children of the principal driver in a family may be rated as occasional drivers. At one time, female children were included free of charge where as male children were not. Female children drivers are no longer included free of charge. There is an additional charge for both male and female occasional drivers, but the rate charged for males may be higher than that charged for females.

In the situation where one member of a household has his or her license suspended, the partner will likely have to pay a higher premium. The insurance company may feel that the suspended driver is a risk for driving without a license and may increase the partner's premium according to their risk assessment.

Under the *Insurance Act*, FSCO reviews all applications and the Superintendent will approve them if certain statutory standards related to risk classification and rates are met. Insurers have a right to request a hearing if approval is not given and the Superintendent holds a hearing if it is in the public interest to do so.

OIC (FSCO) Hearing

In 1997, the former Ontario Insurance Commission (OIC) received application from an insurer that proposed a new risk classification and rate system based on criteria not directly related to driving. A background paper prepared by OIC staff took the position that several elements of the proposed risk classification system were not just and reasonable and did not distinguish fairly between the risks due to their social policy implications. This position does not necessarily reflect the past or present position of the then OIC (now FSCO). The OIC did not approve the application and, as required by the *Insurance Act*, scheduled a hearing on the matter.

The insurer subsequently withdrew its application before commencement of the hearing. However, it is worth noting that the Ontario Human Rights Commission submitted comments to the OIC (see Appendix). The Commission stated that certain risk classification factors under the insurer's proposed system, namely: credit card ownership, bankruptcy status, employment status and stability, and residence status and stability, might be found to contravene Part I of the *Code* on the grounds of marital status. Also, the Commission had concern that such criteria might have an adverse impact on women, youth and recent immigrants.

The Commission then went on to say that it is unclear whether a Board of Inquiry or a Court would find that the insurer's proposed risk classification system "is based on a sound and accepted insurance practice" as was found in *Zurich*. It is also questionable whether it would be found that "there is no practical alternative" to the insurer's proposal.

The Commission further stated that the *Zurich* decision means on the one hand that the insurance industry can contravene certain grounds under Part I of the *Code* if it can show under section 22 that such a practice is adopted "for the purpose of achieving the

legitimate business objective of charging premiums that are commensurate with risk". At the same time, the Court made it clear that the insurance industry should not continue indefinitely to use discriminatory criteria for rate setting and stated that "the industry must strive to avoid setting premiums based on enumerated grounds". When these two aspects of the *Zurich* decision are read together, it might be argued that any newly proposed classification system, even if shown to be a better measure of risk, should at least not further contravene Part I of the Code any more than any current classification system does. And in fact, such a newly proposed system should strive to avoid determining risk based on enumerated grounds.

Irrespective of the majority decision in *Zurich* and the section 22 exception under the Code, the OIC appears to apply a different interpretation of what are "reasonable" and bona fide risk classification criteria. The OIC background paper argued a similar contention to the opinion of the two dissenting judges in the *Zurich* case. These judges found that a statistical correlation is not sufficient to justify the reasonableness of a discriminatory practice. There must be a causal connection.

In its *Final Report* response to the insurer's application, the OIC stated that any new risk classification variable must pass all tests set out in the *Insurance Act* (section 412.1 in particular, see Appendix). It goes on to say that apart from a statistical relationship, risk classification criteria must also make a **fair** distinction. Furthermore:

One indicator of the reasonableness of a risk classification system is its causality, i.e. the insured should be able to logically deduce how they are being rated and see the effect that their driving characteristics has on their rate (OIC *Final Report*, p.7).

The majority decision in *Zurich* does not rely on a "causal connection" but simply a statistical correlation as sufficient to justify the reasonableness of a discriminatory business practice. The position articulated in the OIC's background paper that an insured motorist should be able to see how their driving affects their insurance rate thus appears to be a more stringent test of "reasonableness" than found in the *Zurich* interpretation of section 22 of the Code.

An auto insurance complaint today might be decided differently than in *Zurich* in that a Board of Inquiry or Court might not only consider that the industry could have by now come up with alternatives to traditional discriminatory risk classification criteria, but might also take into account the position as articulated in OIC's background paper that there should be a causal connection between risk classification and driving characteristics.

US Jurisdiction

It has been reported that some jurisdictions in the United States do not use age, sex & marital status in setting auto insurance rates. Massachusetts, for example, uses a "Safe Driver Insurance Plan" that is based on driving record and a points system and not upon age, sex or marital status, except that there is a discount for those aged over sixty-five.

DISABILITY AND INSURANCE

Baer's *Study Paper on the Legal Aspects of Long-Term Disability Insurance (supra)* serves to clarify some definitions and concepts in the area of disability insurance. Baer states that in Ontario, "disability insurance refers to a rider written as part of a life insurance contract, and 'accident and sickness insurance' is the more generic term used in non-life insurance contracts." Similarly, disability insurance is regulated by two different parts of the *Insurance Act*. Baer believes it no longer serves any functional purpose and recommends that "all disability insurance whether undertaken as part of a life insurance contract or not be subject to a single set of statutory rules."

Moreover, Baer uses the term disability insurance to refer to insurance which is designed to replace lost income or to compensate for loss of enjoyment. He distinguishes this from insurance designed to cover medical expenses.

Baer points out that the *Insurance Act* does not distinguish between short and long-term disability, whereas the industry and the Canadian courts do. Short-term benefits are often provided as part of the employer's sick leave policy and are not included under long-term disability. However, group disability insurance policies often combine short and long-term occupational coverage. "That is, to receive short-term benefits, claimants must be disabled from performing their usual occupation, but to receive long-term benefits they must be disabled from performing any occupation."

Baer also stipulates that the *Insurance Act* distinguishes between individual and group disability insurance contracts, and that Statutory Conditions do not apply to group disability insurance. At the same time, most disability insurance is provided under group policies from employers or other organizations.

He goes on to say that, "Much disability insurance (particularly group insurance) is now sold with little if any rating. That is, all members of an organization may be accepted into a group plan with membership in the group (such as employment) used as a rough proxy for good health, and a limited enrolment period for participation in the plan used to guard against adverse risk selection. The risk may be further controlled by various policy exclusions (particularly an exclusion relating to a prior medical condition)."

Section 25(3) Defences

Section 25(3) offers two defences to insurance companies and employers who decline coverage to an employee because of a **pre-existing handicap**:

- Section 25(3)(a) allows other employee disability or life insurance plans to make distinctions based on disability provided that the distinction is reasonable and *bona fide*, and provided that it is because of a pre-existing handicap and provided that the handicap substantially increases the risk.

- In section 25(3)(b) group insurance policies for employee groups that are fewer than 25 in number, or that are employee-pay-all plans, can make distinctions based on disability provided that the distinction is reasonable and *bona fide* and provided that the distinction is made on the ground of a pre-existing handicap.

In order to be successful in its defence under section 25(3)(a) the respondent must show that:

- The distinction addresses a **pre-existing handicap**;
- The handicap excluded is one that **substantially increases the risk**; and,
- The distinction is **reasonable and bona fide**.

Section 25(3)(b) is less onerous, as a respondent does not have to show that the handicap substantially increases the risk.

Employers and insurers who make distinctions based on handicap in group insurance contracts in employment situations which do not fall within the requirements of the section 25(3) exemptions, are not entitled to a special defence under the *Code*.

Pre-Existing Handicap

The insurance industry uses exclusion clauses in long-term disability contracts to restrict individuals from making claims for conditions that pre-existed the effective date of coverage. These exclusion clauses are apparently intended to protect the insurer from individuals who join an employer company primarily to obtain protection for an anticipated health problem that the insurer and employer are unaware of. The insurance industry calls this behaviour "adverse selection".

Pre-existing condition limitations may vary, but they all limit coverage for some period of time for **any** condition that the employee was diagnosed or treated for during some period of time prior to the effective date of coverage. The limitation in an exclusion clause is usually temporary. The employee will likely receive coverage for other conditions on the effective date and deferred coverage for the pre-existing condition.

In the case of *Thornton v. North American Life Assurance Company et al.*⁵, the complainant alleged discrimination based on handicap as a result of an exclusion clause in a long-term disability plan offered by his employer. The exclusion clause in that plan prohibited employees from receiving long-term disability benefits if the employee received care or treatment by a physician in the 90 day period prior to the date the insurance became effective. The complainant had visited his physician twice in the first 90 days of his employment in order to discuss his HIV positive status. Eleven months into his employment Mr. Thornton applied for long-term disability benefits because of an illness related to his HIV status.

⁵ *Supra*, note 2.

The Board of Inquiry dismissed the complaint. It accepted that “the practice of including exclusionary clauses in insurance contracts where there are fewer than 100 employees in the insured group to be reasonable. Where there are larger numbers of employees such clauses are not necessary because the risk is spread over a greater number” (see Appendix, Case Summaries). The Board also found that there was no practical alternative to this practice.

A problematic scenario arises when an individual visits a doctor during the exclusionary period prior to coverage for a minor ailment that is not yet diagnosed as a pre-existing handicap. That is, the ailment that shows up prior to coverage is deemed to be a symptom of a pre-existing condition only after the point coverage begins. It might be argued that given that the intent of exclusionary clauses for pre-existing handicap is to protect the insurer from adverse selection, the seriousness of a condition should be known or diagnosed during the exclusionary time period prior to coverage in order to deny benefits.

A related issue is the notion of the insured’s duty to disclose material facts such as a pre-existing condition. Baer explains that insurance contracts are considered to be contracts of *utmost good faith* where the insured is required to disclose to the insurer all material facts. A material fact is “any fact that would have influenced a reasonable insurer to decline the risk or to have stipulated for a higher premium.” However, Baer remarks that “the common law obligation of the *utmost good faith* is widely recognized to be too onerous and unfair.”

Baer finds that the *Insurance Act* has adopted modifications to the requirement of the utmost good faith, although the second is adopted by inference:

- That after a two year incontestability period, a claim cannot be avoided on the basis of concealment and misrepresentation in the absence of fraud; and,
- That the disclosure obligation is limited to information solicited in the application form or in any required medical examination.

Baer also recommends that the *Insurance Act* expressly provide that the insured’s duty to disclose be confined to answering all questions to the best of their knowledge and belief.

Substantially Increased Risk

Section 25(3)(a) presents a higher standard for employers and insurers due to the fact that the pre-existing handicap must substantially increase the risk. The Board of Inquiry in **Thornton** defined "risk" to refer to the chances of a claim being made for the insurance benefit which is the subject of the exclusion.

Under group disability insurance the insurer does not attempt to assess the degree of risk associated with individual employees. The insurer accepts that some members of the group will be at risk of making a claim.

Achieving a normal spread of risk in a group depends on the group being large enough to be statistically reliable. Very large groups of employees likely have a normal spread of risk. According to the insurance industry, groups of less than 100 employees are not expected to represent a normal spread of risk.

An insurance company may not actually assess whether a condition substantially increases the risk of claims being made. At the same time, in order to meet the requirements of section 25(3)(a) an insurance company should ensure that any distinction based on pre-existing handicap applies only to those handicaps that involve a high degree of risk. However, meeting this *Code* requirement itself raises concerns.

The exclusion of individuals who have a "pre-existing handicap that substantially increases the risk" results in unequal treatment in employment because of handicap. This denial of long-term disability coverage is a barrier for persons with disabilities who have not yet entered the work force and for persons who are employed but could not change employment without losing the coverage they have with their present employer. Individuals who have HIV/AIDS are particularly vulnerable at present. Insurance representatives have used the expression "you can't insure a burning house" to illustrate the difficulty in insuring someone with HIV/AIDS. Some AIDS organizations have been unable to obtain group insurance plans for their employees because the insurance industry deems the entire employee pool present too high a risk.

Foster Higgins, a human resources consulting firm, published the results of a study that attempted to predict HIV-related costs in group insurance plans⁶. The results of the study indicate that costs from long-term disability claimants with AIDS or AIDS-related disorders were not as high as originally expected. The article suggests several reasons for lower than expected costs. One reason is that most long-term disability claims are offset by Canada Pension Plan disability payments. Hospital stays are also short and may not be billed to a company plan and there is assistance for out-of-hospital drug costs. The article concludes that "a typical claim may cost the benefit plan a total of \$100,000, plus a death claim – this is less than many LTD claims". The article ends by suggesting that employers can consider various measures to control the costs for life insurance and long-term disability programs.

Thus, in determining whether a pre-existing handicap substantially increases the risk, an insurer might have to apply an analytical model, such as the above comparative cost analysis, in order to claim a defence under 25(3)(a) of the *Code*.

Reasonable and Bona Fide

The exclusion, distinction, or preference in an insurance policy must be "reasonable and *bona fide*". The "reasonable and *bona fide*" test developed by the majority of the Supreme Court in ***Bates v. Zurich Insurance*** may also be applied in section 25(3). As in ***Zurich*** and ***Thornton***, respondents are unlikely to be challenged on the *bona fide* part of the test.

⁶ Foster Higgins Bulletin, "The Impact of AIDS on Benefit Programs" (Toronto: Foster Higgins, 1994)

Turning to the "reasonableness" test, a Board of Inquiry must examine whether:

- The exclusion, distinction or preference is based on a sound and accepted insurance practice; and
- There is no practical alternative.

In other words, a Board of Inquiry must assess whether there is enough statistical and actuarial evidence to support the practice that excludes employees from insurance benefits. In *Thornton*, for example, the respondent company asserted that the purpose of the exclusion clause was to prevent adverse selection. The Board of Inquiry found that the respondent had not made a viable statistical case for the necessity of such a clause. The Board, however, found that the exclusion clause was justified for other reasons.

Not only must an exclusion, distinction or preference be shown to be statistically valid, but there must also be no practical alternative available. In *Thornton* the Board did not accept the alternatives proposed by the complainant. The Canadian Life and Health Insurance Association has suggested that alternatives for group plans where there is a small risk pool are possible, such as applying a waiting period for all plan members and all conditions, or restricting the criteria under which group insurance would be available.

Section 22 Defence

The Section 22 defence in the *Code* includes individual accident, sickness or disability insurance or group insurance not part of an employment situation where distinctions may be made based on age, sex, marital and family status, or handicap, but these distinctions must be made on reasonable and *bona fide* grounds.

Underwriting Criteria

Baer, in his *Study Paper on Disability Insurance*(supra), explains that:

Underwriting is not an exact science. Underwriters rely both on actuarial evidence and experience. They base the likelihood of loss on both the physical and the moral hazard. In the life and health insurance field, the physical hazard includes all those medical, occupational and vocational factors which the underwriter decides would affect the risk. The moral hazard includes those factors associated with the individual insured's personality which the underwriter decides would or might affect the risk.

He suggests that such insights gained from expert or professional underwriting experience "may be hard to distinguish from attitudes in society based on stereotype or prejudice." He also notes that few Canadian courts have probed the evidence of whether "underwriting criteria are unreasonable because [they are] inconsistent with modern notions of human rights."

Baer points out that the Ontario *Insurance Act* contains no specific control on the underwriting criteria that can be used in disability insurance.

As mentioned earlier under the discussion on auto insurance, the *Act* has a general prohibition against “unfair practices” under Part XVIII. Section 438 of the *Insurance Act* states that the phrase “Unfair practices” are ... “any unfair discrimination in any rate or schedule of rates between risks in Ontario of essentially the same physical hazards in the same territorial classification”. Baer further states:

So far, the Superintendent (of Insurance) has exercised his authority with restraint. This restraint is consistent with a long tradition in Canada of treating rate setting as largely a private matter, not subject to public control. This tradition is in sharp contrast to that in most American jurisdictions where the determination of rates is seen to involve significant public issues of distributive justice and equity amongst insureds.

This lack of public control has extended to human rights legislation in most provinces...

With respect to Ontario, this last point means that the *Human Rights Code* provides exceptions or defences to discriminatory practices in the insurance industry, defences that arguably have not been as narrowly interpreted as human rights jurisprudence would require.

Although Baer believes that individual underwriting should still be allowed for persons insured under group disability plans, he outlines several questions on whether there should be public control on the underwriting criteria used:

- Do the criteria require insurers to become too intrusive?
- Are the criteria supported by scientific or actuarial evidence?
- Do the criteria enforce systemic disadvantage in society?
- Is it appropriate to use criteria that are beyond the control of individuals?
- With respect to group plans controlled by employers, do the criteria frustrate the goals of employment equity?

Baer believes that several factors favour public intervention in setting criteria:

- The co-operation necessary in the insurance industry for effective rate setting may discourage the use of innovative criteria;
- The state of scientific knowledge may be such that insurers are left to grope and they use markers or character evidence that arouses serious public concerns about reliability and invasion of privacy. The industry’s attempt to identify groups that are at higher risk of acquiring AIDS is a good illustration;
- Competitive pressure in the insurance industry may re-enforce systemic disadvantage.

Baer finds that the two existing mechanisms for challenging underwriting criteria, human rights legislation and the Charter and the Superintendent of Insurance’s authority to disallow discriminatory rates have been little used.

Baer places primary responsibility for controlling underwriting criteria from being discriminatory with the Commissioner or Superintendent of Insurance (now simply the Superintendent of Financial Services) because of their expertise. He recommends:

- That the authority of the Superintendent or Commissioner to disallow discriminatory criteria be strengthened by clarifying the factors which should and should not be taken into account and by providing for a more formal public hearing
- That additional public representatives be appointed to assist the Commissioner in making his or her decision

Finally, in order to avoid any adverse effect of health screening on employment Baer recommends:

- Health screening for the purpose of group disability insurance underwriting should not be allowed to evade any human rights standards for access to medical information relating to restrictions in employment arising from a disability unless there is a *bona fide* reason to know more.

Mental Disability

When the insurance industry identified workplace stress as a major risk insurers began to limit long-term disability benefits, often to only 24 months unless the employee is hospitalized, for persons with disabilities caused by nervous and mental conditions. Employers and insurance companies do not have a special defence to this practice.

It could be argued that the differentiation in treatment results in discrimination based on mental handicap. That is, persons with mental disabilities are being treated differently than persons with physical disabilities. A common response from insurance companies is taken from a narrow interpretation of judicial comments in **Andrews**⁷. Respondent insurance companies have argued that the concept of equality rights involves a comparative approach. The proper approach is to compare the treatment of disabled individuals with people who are not disabled. And since non-disabled employees have no access to disability benefits, there is no discriminatory treatment by the employer in the provision of its disability benefits.

This argument was also made by a respondent employer in **Gibbs** before the Saskatchewan Court of Appeal⁸. In that case an employee who was suffering from a mental illness was denied benefits after a 24-month period. If she had been hospitalized she would have been entitled to benefits. Persons with physical disabilities were entitled to benefits until 65 years of age or retirement on pension.

⁷ *Andrews v. Law Society of British Columbia* (1989), 10 C.H.R.R. D/5719 (S.C.C.)

⁸ *Battlefords and District Co-operative Ltd. v. Gibbs and Saskatchewan Human Rights Commission* (unreported decision, June 14, 1994, Saskatchewan Court of Appeal).

The reasoning used by respondents in such circumstances is faulty in that it is not in keeping with the substantive equality approach developed in the **Andrews** case. After acknowledging equality rights involves a comparison of conditions of others, the Supreme Court in **Andrews** went on to emphasize that "the main consideration must be the impact of the law on the individual or group concerned".

The Saskatchewan Court of Appeal in **Gibbs** rejected the respondent's argument that the appropriate comparison is between persons with disabilities and persons without disabilities. The Court held that to determine the appropriate comparison one must begin the analysis with the person alleging discrimination and define the group to which she or he belongs.

Finally, the Supreme Court rejected an appeal in the **Gibbs** case⁹ and found that "It is not fatal to a finding of discrimination that not all persons in the group bearing the relevant characteristic have been discriminated against. Discrimination against a subset of the group, in this case those with a mental disability, can be considered discrimination against persons with disabilities".

The Canadian Life and Health Insurance Association (CLHIA) stated that the distinctions between physical and mental conditions, or between some mental conditions and others, "relate to the extreme difficulty in evaluating the degree of disability resulting from conditions, even with the best professional advice, and thus to the difficulty in determining when disability exists to the extent anticipated under the definition in the contract and when such degree of disability ceases to exist."

The CLHIA went on to say that the use of such distinctions between physical and mental conditions has declined in recent years. However, the CLHIA qualified this advance with the following comment: "these advances have been offset to some degree by major increases in stress-related conditions, and for some groups it is still deemed necessary to employ such distinctions to keep the overall risk within acceptable bounds so that full coverage can be provided for other conditions".

It appears clear from these comments that the insurance industry prefers to insure individuals with physical conditions over individuals with mental conditions. Interestingly, respondents have not argued that the risk associated with mental conditions is too high to insure. It could be argued that this differential treatment is based on assumptions and stereotypes surrounding mental illness. The Supreme Court Canada decision in **Gibbs** demonstrates that such differential treatment will not be tolerated.

HIV/AIDS

The Commission's *Policy on HIV/AIDS-Related Discrimination* states that all persons who have or have had, or who are believed to have or have had, or are perceived to have, AIDS or HIV-related medical conditions, including those who do not show symptoms of

⁹ *Gibbs v. Battlefords and Dist. Co-operative Ltd. (1996), 27 C.H.R.R. D/87 (S.C.C.)*

AIDS or AIDS-related illnesses, are deemed to have a "handicap" and are entitled to protection under the *Code*.

In the early 1990's, two complaints were filed with the Commission by the same complainant against two different respondents on issues relating to discrimination in insurance because of HIV/AIDS status. The complaints did not result in a Board of Inquiry. Nonetheless, a discussion of the two cases serves to highlight issues of discrimination because of "perceived" or potential future handicap.

One complaint relates to a denial of individual life insurance and the other relates to a denial of group mortgage insurance. In both cases, the complainant was denied insurance because he was deemed to be in an uninsurable high-risk group by virtue of the fact he is married to a woman who is HIV+.

The CLHIA explained group mortgage insurance in the following manner. Because group mortgage insurance involves significant amounts of insurance and because it is almost always optional, unlike employment related group insurance, it is important to evaluate the risk of each applicant. Procedures for group mortgage insurance, therefore, more closely resemble individual insurance. The streamlined administrative system is unable to accommodate non-standard risks that are significantly above the norm, unlike individual insurance.

If we accept the above description as correct, the analysis of the HIV-insurance complaint would then have to focus on the assessment of risk accorded to the Complainant based upon the fact he is married to a woman who is HIV+. The respondents, two insurance companies in Ontario, assessed the risk of someone living in a conjugal relationship with someone who is HIV+ as being too great a risk. The two cases focus on the "reasonable and *bona fide*" analysis of this risk assessment.

There is no reason to believe the respondents were not acting in a manner that meets the *bona fide* test. That is, they adopted the practice honestly, in the interests of sound and accepted business practice and not for the purpose of defeating the rights protected under the *Code*. The main question is whether the respondents in the two cases met the reasonableness test. That is, is the assessment based on a sound and accepted insurance practice? And was there a practical alternative available?

If the complaints had been sent to a Board of Inquiry, the Commission would have had to present expert medical evidence to prove that the respondent's assessment of risk was not based on credible actuarial evidence. The respondents presume that two persons living together in a conjugal relationship will engage in sexual intercourse. They suggest there is a reasonable basis to conclude that the Complainant may be infected at present or within the term of the insurance contract.

As in most assessments of risk in the insurance industry, the assessment is based on broad generalizations rather than individual circumstances. The respondents assigned the Complainant to a high-risk group simply because of his association with his wife.

The case analyses in the two complaints detail the problems with the respondents' risk assessment of the Complainant. The officer's investigation revealed evidence that the complainant's chances of becoming infected from his wife are "very low to almost zero". There are two main reasons for this conclusion: first, the rate of transmission from female to male is very low and secondly, the complainant and his wife have abstained from sexual relations since January 1991. The officer summarizes by stating: "The fact of his being married to and living in a conjugal relationship with an HIV+ woman cannot be taken as an indicator of his "high risk status". The distinction is one between "risky behaviour" and "risky relationship".

A strong argument could be made, supported by the necessary expert evidence, that the respondents' assessment of risk was not based on a sound and accepted business practice that was adopted for the purpose of achieving the legitimate business objective of charging premiums that are commensurate with risk.

With regard to the second part of the "reasonableness" test, the officer suggested that there was a practical alternative available at the time the coverage was denied. The officer stated there is no developed classification system to evaluate HIV-related risks as there was in the automobile insurance industry at issue in **Bates v. Zurich** case. The alternative that did exist was to assess the complainant's risk in terms of his behaviour rather than by group identification.

Diabetes

In two other complaints that have come before the Commission, a husband and wife applied for group mortgage insurance. The wife was denied because she has diabetes. Her husband's application was approved but the group insurance was denied. The wife alleges discrimination based on handicap. The husband claims he was denied a service because of his association with his wife.

The question in these complaints would again be whether the data used to assess the risk of a condition is accurate. That is, is the practice of categorizing diabetics as high risk based on a sound and accepted business practice that was adopted for the purpose of achieving the legitimate business objective of charging premiums that are commensurate with risk? Medical evidence is required to assess whether all diabetics are a high risk or if individual history and behaviour are important factors in the assessment of risk.

The Court of Appeal in Nova Scotia dismissed an appeal by the Nova Scotia Human Rights Commission and Mr. Scott Slipp on the grounds that Mr. Slipp's diabetes is highly relevant to the assessment of risk and that group mortgage insurance offered by a bank was not a service customarily available to the public.¹⁰ Although respondents may rely on this decision it is not very helpful in relation to the Ontario *Human Rights Code* because service in the Nova Scotia legislation is narrowed to services "customarily available to the public" and there is no "reasonable and *bona fide*" exemption.

¹⁰ Nova Scotia (Human Rights Comm.) v. Canada Life Assurance Co. (1992), 88 D.L.R. (4th) 100 (N.S.C.A.).

RISK ASSESSMENT

Insurance companies use actuarial data analysis for the purpose of setting premiums and disallowing coverage to individuals considered to be too high risk. Once an individual has coverage he or she is not necessarily guaranteed access to benefits. The author of an article entitled "The Industry of the Living Dead" studied reported court cases dealing with disability insurance. He observed that the cases "suggest an industry actively resisting claims which the courts later uphold"¹¹.

Of course, persons who are at a higher risk are the very individuals who need insurance coverage. There are no legal obligations directly relating to the assessment of risk. As noted earlier, the "unfair practices" provision under PART XVIII of the *Insurance Act* (see Appendix) is the only deterrent and the Superintendent of Insurance rarely takes action under the provision.

Insurance companies tend to use general medical information with regard to a particular condition without taking an individual's specific circumstances into consideration. The Canadian Life and Health Insurance Association (CLHIA) has stated that medical research is the key component in risk evaluation procedures.

Insurers often overlook both individual behaviour and social programs that provide financial and other support to persons with disabilities. It could be argued that if insurers considered such factors their assessment of risk would likely not be as high. This approach is supported by the Foster Higgins study¹².

It could also be argued that the industry's approach to risk assessment does not meet the Supreme Court test of a sound and accepted insurance practice. That is, this practice of making broad generalizations when assessing an individual's degree of risk does not achieve the legitimate business objective of charging premiums that are commensurate with risk.

Genetic Testing

Genetic testing may become a method of screening applicants for hereditary diseases. For example, Canadian scientists recently identified two genes that produce susceptibility to Type-One diabetes¹³. Genetic tests for breast cancer are also being developed. James Watson, a Nobel laureate in chemistry, has suggested that insurance companies be prohibited from conducting genetic tests on potential policyholders. He noted that there is not currently a law prohibiting such tests by insurance companies¹⁴.

¹¹ David Schulze, "The Industry of the Living Dead: A Critical Look at Disability Insurance" (1993) 9 Journal of Law and Social Policy 192

¹² *Supra*, Note 6

¹³ Barbara Wickens, "On the Leading Edge: Canadians are at the Forefront of Diabetes Research" (1994) 107(4) Macleans 58.

¹⁴ Stephen Strauss, "Bar Genetic Tests on Policyholders, Nobel Laureate Says" Nov. 4, 1994 Globe and Mail 7.

The ramifications of genetic testing could be immense for individuals showing a predisposition to a disease. The CLHIA has said that the likelihood of the insurance industry using genetic testing on a screening basis is very low. However, if an applicant has undergone genetic testing he or she would be obliged to disclose this information. Insurers would then consider the test results as part of their risk assessment. Insurers may decide not to assume the risk in such cases, especially with the increased risk of adverse selection.

The CLHIA believes that in a way the insurance industry already uses a form of "genetic testing" by considering an individual's family history. For example, someone with a history of Huntington's disease may not be offered coverage. The individual would likely be given the opportunity to be tested to clarify whether or not he carried the gene.

SAME-SEX COUPLES

As mentioned above, section 25(2) of the *Code* allows distinctions on the basis of marital status to be made in group insurance schemes as long as those schemes are in compliance with the *Employment Standards Act*. The Regulations of the *Employment Standards Act* also allow employers and insurance companies to discriminate on the basis of marital status in pension plans and group insurance contracts.

The combination of this defence and the definition of marital status in the *Code* result in differential treatment in employment benefits for gay and lesbian employees. The spouses of these employees are not entitled to the same benefits as are opposite sex spouses.

In ***Leshner v. Ontario***¹⁵, the Ontario government had refused to extend coverage to same-sex spouses in its pension plan because of the federal *Income Tax Act*. The Board of Inquiry in ***Leshner*** ordered the government to "read down" the definition of marital status in the *Code* to delete the opposite sex restriction. The Board also held that section 25(2) is of no force or effect to the extent of its inconsistency with the *Charter*. The Board ordered the provincial government to immediately provide equivalent survivor benefits to its gay and lesbian employees through an arrangement outside of the existing pension plan.

Furthermore, the Board of Inquiry directed the Ontario government to make representations to the Federal government within three years to persuade the Federal government to amend the *Income Tax Act* to permit the registration of pension plans which offer benefits to same-sex spouses. The Board also directed the Commission to monitor the province's efforts. In March 1997, the Chief Commissioner sent a letter to the Minister of National Revenue urging him to remove the barrier created by the *Income Tax Act*.

Since then, the Ontario Court of Appeal recently heard the case of ***Rosenberg and CUPE v. Revenue Canada***, which argued that the federal *Income Tax Act* definition of spouse as a member of the opposite sex is contrary to *Charter* guarantees of equal

¹⁵ *Leshner v. Ontario* (No. 2) (1992), 16 C.H.R.R. D/184 (Ont. Bd.Inq.)

treatment.¹⁶ The Court allowed the appeal and required that the words “and same sex” be read into the *Act*.

In a 1995 landmark case, the Supreme Court of Canada heard an appeal in ***Egan v. Canada***¹⁷ on the definition of spouse. In this case, the same-sex spouse of a pensioner was denied a spousal allowance because he did not meet the definition of spouse in the *Old Age Security Act*. The Court ruled that differential treatment of persons in same-sex relationships, as compared with persons in opposite sex relationships, is discrimination on the basis of sexual orientation.

In September 1996, the Ontario Board of Inquiry released a crucial decision dealing with two complaints on the issue of sexual orientation. In ***Dwyer and Simms v. Municipality of Metropolitan Toronto & Attorney General of Ontario***, the two complainants, a gay man and a lesbian, challenged their exclusion from the spousal benefits provisions of their respective employers' pension benefits, insured health benefits and uninsured employment benefits plans.¹⁸ The legal issues raised in this hearing relied on the Supreme Court of Canada's earlier decision in ***Egan v. Canada***, as well as a challenge to the constitutionality of certain provisions in the *Code*.

The Board of Inquiry found in ***Dwyer and Simms*** that the respondents had discriminated against the complainants because of their sexual orientation. The Board further ruled that the *Code* must be read as a whole and consideration must be made of the opposite sex definitions of spouse and marital status found in the *Code*. The Board applied a *Charter* analysis to the opposite sex definitions of spouse and marital status and concluded that these definitions contravened the equality rights guaranteed by s. 15 of the *Charter* and were not reasonable or democratic limits under s. 1 of the *Charter*. The Board decision required municipalities to extend insured health benefits and uninsured benefits to the same-sex spouses of employees.

It should be noted that the ***Dwyer and Simms*** case is currently under appeal. Also, the more recent decision of the Supreme Court of Canada in ***Bell and Cooper***¹⁹ held that a body such as the Canadian Human Rights Commission, as well as tribunals appointed pursuant to a referral by the Commission, have no jurisdiction to find that a provision in their enabling legislation is unconstitutional.

In a more recent case on the issue of spousal benefits and discrimination against same-sex couples, the Ontario Court General Division in ***Kane v. Axa Insurance*** ruled in October 1997 (see Appendix), that the company's refusal to pay a spousal benefit after the accidental death of Kane's lesbian partner, violated her rights under the *Charter*.²⁰ The Court found Ontario's *Insurance Act* to be discriminatory and ordered the *Act* to be

¹⁶ Rosenberg v. Canada (Attorney General) (1998), 38 O.R. (3d) 577 (Ont. Court of Appeal).

¹⁷ *Egan v. Canada* (1995), 124 D.L.R. (4th) 609 (S.C.C.).

¹⁸ *Dwyer v Toronto (Metro)* (No.3) (1996), 27 C.H.R.R. D/108.

¹⁹ *Copper v. Canada (Human Rights Comm.)* (1997), 27 C.H.R.R. D/173 (S.C.C.)

²⁰ *Kane v. Ontario (Attorney General)* (1997), 152 D.L.R. (4th) 738.

changed to include members of same-sex couples in the definition of spouse. The case is under appeal.

In another case, the Ontario Court General Division decision of December 1998 in ***OPSEU Pension Plan Trust Fund v Ontario*** ordered the Ontario government to change the *Pension Benefits Act* definition of spouse to include same-sex couples.²¹ The Court had found that the *Act's* current definition of spouse as a relationship between a man and a woman is unconstitutional. The *Act* sets minimum standards for all pension plans in the province.

Most recently, the Supreme Court of Canada rendered its decision in ***Attorney General of Ontario v. M. and. H.***, where it ruled that the opposite-sex definition of "spouse" in Part III of Ontario's *Family Law Act* is unconstitutional.²² Although this case is unrelated to employment benefits and insurance, it is once again affirmation by higher courts that definitions of spouse and marital status that exclude same-sex couples from enjoying the same rights and responsibilities as other couples are discriminatory.

Finally, in June 1997 and again in July 1999 of this year, the Chief Commissioner wrote to the Attorney General of Ontario stating his concern with respect to exclusionary definitions of "spouse" and "marital status" in Ontario statutes, and their discriminatory effect on same-sex couples.

PREGNANCY

The Commission's *Policy on Discrimination Because of Pregnancy* states that subject to *bona fide* requirements, denying or restricting sick leave benefits to a woman while on maternity leave may constitute a violation of the *Code*.

Section 25(2) offers respondent employers and insurance companies a defence to discrimination based on sex, marital status, age or family status. Distinctions in employee pension plans or employee group insurance plans based on age, sex, marital status or family status do not offend the *Code* if they comply with the regulations under the *Employment Standards Act*.

Section 33(2) of the *Employment Standards Act* prohibits employers from arranging benefit plans that make a distinction, preference or exclusion because of age, sex or marital status of the employees except as provided for in the Regulations. Regulation 321 permits differentiation between employees on the basis of age, sex and marital status in the provision of pension, life insurance, disability and health insurance benefits (see Appendix).

²¹ *Ontario Public Service Employees Union Pension Plan Trust Fund (Trustees of) v. Ontario (Management Board of Cabinet)* (1998) 20 C.C.P.B. 38

²² *Attorney General of Ontario v. M. and. H.*, Unreported decision of the Supreme Court of Canada released on May 20, 1999.

Sub-section 8(c) of Regulation 321 permits the exclusion of women from benefits under a short or long-term disability plan during the period of absence she is entitled to under Part XI of the *Employment Standards Act*. Part XI of the *Act* entitles women to pregnancy leave and both men and women to parental leave. The result of subsection 8(c) is that women can be excluded from benefits under a disability plan during parental leave while a male employee cannot be excluded.

Regulation 321(8)(c) still stands even though it would likely be found to be unconstitutional given the Supreme Court of Canada decision in ***Brooks v. Canada Safeway***²³. The Court found that pregnancy provides a perfectly legitimate health-related reason for not working and as such, women should be entitled to sick or disability benefits during that portion of the pregnancy leave that they are unable to work for valid health reasons.

An Alberta court decision in ***Alberta Hospital Association v. Parcels*** endorsed the *Brooks* principle that a health-related reason for absence from the workplace by a pregnant employee is not to be treated differently from other health-related absences.²⁴ This applies generally where the woman is pregnant and where the condition which requires time off is associated with pregnancy.

More recently in March 1998, the Ontario Divisional Court ruled on an appeal from a Board of Inquiry decision in ***Crook v. Ontario Cancer Treatment and Research Foundation & Ottawa Regional Cancer Centre***²⁵. *Crook* alleged that the respondent had denied her the use of sick leave benefits during a period after she had given birth.

The employer's appeal is argued on two bases: first, that there is no discrimination within Section 5 of the Code in barring women on unpaid leave of absence from the sick leave plan after childbirth, and second, that the combined effect of Section 25(2) of the Code, with the *Employment Standards Act* and its regulations regarding benefit plans, provides a defence to any discrimination.

The Court found that the defence in section 25(2) of the Code was not available to the respondent because vacation leave is not a form of leave in accordance with the *Employment Standards Act* where the exclusion of women from benefits under a disability plan is permitted. Furthermore, the sick benefits plan was self-funded and not a contract of group insurance as stipulated under section 25(2) of the Code. The Court relied on the *Brooks* decision and ruled that the Board of Inquiry in *Crook* correctly found that the application of the employer's sick leave policy constituted direct discrimination on the bases of pregnancy and sex by denying benefits to the complainant and those like her seeking benefits after childbirth for the period of personal recovery.

²³ *Brooks v. Canada Safeway Ltd.* (1989), 10 C.H.R.R. D/6183 (S.C.C.)

²⁴ *Alberta Hospital Association v. Parcels* (1992), 17 C.H.R.R. D/167 (Alta. Q.B.).

²⁵ *Ontario Cancer Treatment & Research Foundation v. Ontario (Human Rights Commission)* (1998), 34 C.C.E.L. (2d) 56, 108 O.A.C. 289 (Ont. Div. Ct.); upholding *Crook v. Ontario Cancer Treatment & Research Foundation* (No.3) (1996), 30 C.H.R.R. D/104 (Ont. Bd. of Inquiry).

In Ontario, **Brooks** and **Parcels** have not been fully integrated into the legal protections available to women who are absent for pregnancy-related health reasons.

Practically speaking, this means that the right to receive benefits under disability plans ends when a woman chooses to go on to a Part XI leave under the *Employment Standards Act* (pregnancy or parental leave). But if an employer offers disability benefits to other employees who are off on other kinds of leave such as educational leaves or sabbaticals, then the *Employment Standards Act* provides that benefits should also be paid to women on pregnancy leave and parental leave.

Finally, a woman may have health problems related to her pregnancy that forces her to be away from work *before or after* her pregnancy leave or parental leave. She can access health benefits under a workplace sick or disability plan in this situation.

Regardless of whether or not a sick-leave plan is based on a contract of group insurance, women on maternity leave continue to be entitled to other benefits under employment-related benefit plans including pension plans, life insurance plans, accidental death plans, extended health plans and dental plans.²⁶ Employers are also required to continue to make contributions to such plans.²⁷

IMPLICATIONS FOR THE ONTARIO HUMAN RIGHTS COMMISSION

The Commission is proposing to undertake the following actions and strategies in order to better promote the protection of human rights in insurance:

- Cite principles and rulings in case law (see Appendix) that promote protection from discrimination in insurance on prohibited grounds of the *Code*;
- Review current and new complaints in light of the decision in **Zurich** where the Supreme Court of Canada made it clear that the insurance industry should not continue indefinitely to use discriminatory criteria for rate setting, and that "the industry must strive to avoid setting premiums based on enumerated grounds";
- Promote the principle that any newly proposed risk classification system, even if shown to be a better measure of risk, should at least not further contravene rights under Part I of the *Code* any more than any current classification system does. And in fact, any newly proposed system should strive to avoid determining risk based on enumerated grounds;
- On a case by case basis, consider bringing forth complaints where there is only a "correlation" and no apparent "causal" connection between the alleged discriminatory risk factor and the intended purpose of the insurance;

²⁶ Subsections 42(1) and (2) of the *Employment Standards Act*.

²⁷ Subsection 42(3) of the *Employment Standards Act*.

- Continue to monitor jurisprudence related to insurance and human rights law for implications relating to policy development and complaints before the Ontario Human Rights Commission;
- Encourage the Superintendent of Financial Services to promote the protection of human rights in insurance;
- Write to the Ministry of Labour requesting an amendment to Regulation 321 of the *Employment Standards Act*. Sub-section (8)(c) of the Regulation permits the exclusion of women but not men from sick and disability benefits under group insurance plans during pregnancy and parental leaves.
- Write to the Attorney General of Ontario in support of the 1996 *Study Paper on the Legal Aspects of Long-term Disability Insurance* prepared for the Ontario Law Reform Commission, which recommends that there should be greater public control on underwriting criteria in insurance;
- Forward copies of this Discussion Paper to industry representatives, consumer groups and government including the Financial Services Commission of Ontario and the Ministry of Finance for comment, as well as posting an electronic version to the Commission Web site for general public access;
- Encourage the establishment of a joint industry, consumer and government mechanism that would promote dialogue on issues related to human rights in insurance on an ongoing basis.

APPENDICES

RELEVANT LEGISLATION

HUMAN RIGHTS CODE

SERVICES

1. Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap. R.S.O. 1990, c. H.19, s. 1.

CONTRACTS

3. Every person having legal capacity has a right to contract on equal terms without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap. R.S.O. 1990, c. H.19, s. 3.

EMPLOYMENT

5.--(1) Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or handicap.

CONSTRUCTIVE DISCRIMINATION

11.--(1) A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,

- (a) the requirement, qualification or factor is reasonable and *bona fide* in the circumstances; or
- (b) it is declared in this Act, other than in section 17, that to discriminate because of such ground is not an infringement of a right.

RESTRICTIONS FOR INSURANCE CONTRACTS, ETC.

22. The right under sections 1 and 3 to equal treatment with respect to services and to contract on equal terms, without discrimination because of age, sex, marital status, family status or handicap, is not infringed where a contract of automobile, life, accident or sickness or disability insurance or a contract of group insurance between an insurer and an association or person other than an employer, or a life annuity, differentiates or makes a distinction, exclusion or preference on reasonable and *bona fide* grounds because of age, sex, marital status, family status or handicap. R.S.O. 1990, c. H.19, s. 22.

EMPLOYMENT CONDITIONAL ON MEMBERSHIP IN PENSION PLAN

25.--(1) The right under section 5 to equal treatment with respect to employment is infringed where employment is denied or made conditional because a term or condition of employment requires enrolment in an employee benefit, pension or superannuation plan or fund or a contract of group insurance between an insurer and an employer, that makes a distinction, preference or exclusion on a prohibited ground of discrimination.

PENSION OR DISABILITY PLAN

(2) The right under section 5 to equal treatment with respect to employment without discrimination because of age, sex, marital status or family status is not infringed by an employee superannuation or pension plan or fund or a contract of group insurance between an insurer and an employer that complies with the *Employment Standards Act* and the regulations thereunder.

EMPLOYEE DISABILITY AND PENSION PLANS: HANDICAP

(3) The right under section 5 to equal treatment with respect to employment without discrimination because of handicap is not infringed,

- (a) where a reasonable and *bona fide* distinction, exclusion or preference is made in an employee disability or life insurance plan or benefit because of a pre-existing handicap that substantially increases the risk;
- (b) where a reasonable and *bona fide* distinction, exclusion or preference is made on the ground of a pre-existing handicap in respect of an employee-pay-all or participant-pay-all benefit in an employee benefit, pension or superannuation plan or fund or a contract of group insurance between an insurer and an employer or in respect of a plan, fund or policy that is offered by an employer to employees if they are fewer than twenty-five in number.

COMPENSATION

(4) An employer shall pay to an employee who is excluded because of a handicap from an employee benefit, pension or superannuation plan or fund or a contract of group insurance between an insurer and the employer compensation equivalent to the contribution that the employer would make thereto on behalf of an employee who does not have a handicap. R.S.O. 1990, c. H.19, s. 25.

INSURANCE ACT

Note: The *Financial Services Commission Act 1998* amends the *Insurance Act* and replaces the term "Commissioner of Insurance" with "Superintendent of Financial Services".

PART VI AUTOMOBILE INSURANCE

Definitions

224.(1) In this Part,

...

"spouse" means either of a man and a woman who,

- (a) are married to each other,
 - (b) have together in good faith entered into a marriage, or
- Note: On a day to be named by proclamation of the Lieutenant Governor, clause (b) of the definition of "spouse" is repealed and the following substituted:

- (b) have together entered into a marriage that is voidable or void, in good faith on the part of the person asserting a right under this Act, or
- See: 1996, c. 21, ss. 15 (3), 52.
- (c) are not married to each other and have cohabited continuously for a period of not less than three years, or have cohabited in a relationship of some permanence if they are the natural or adoptive parents of a child; ("conjoint")

PART XV RATES AND RATING BUREAUS

Application re risk classification system, rates

410. (1) Every insurer shall apply to the Commissioner for approval of,
- (a) the risk classification system it intends to use in determining the rates for each coverage and category of automobile insurance; and
 - (b) the rates it intends to use for each coverage and category of automobile insurance.

Hearing

412. (9) If the Commissioner notifies an applicant that he or she has not approved an application, the Commissioner shall hold a hearing.

Hearing, public interest

(10) The Commissioner shall not approve an application if the Commissioner considers that it is in the public interest to hold a hearing on the application. R.S.O. 1990, c. 1.8, s. 412 (4-10).

Refusal to approve

412.1 (1) The Commissioner shall refuse to approve an application under section 410 if the Commissioner considers that the proposed risk classification system or rates are not just and reasonable in the circumstances.

Same

(2) The Commissioner shall refuse to approve an application under section 410 respecting a proposed risk classification system that the Commissioner considers,

- (a) is not reasonably predictive of risk; or
- (b) does not distinguish fairly between risks.

Same

(3) The Commissioner shall refuse to approve an application under section 410 respecting proposed rates that the Commissioner considers would impair the solvency of the applicant or are excessive in relation to the financial circumstances of the insurer.

Relevant information

(4) In deciding on an application under section 410, the Commissioner may take into account financial and other information and such other matters as may directly or indirectly affect the applicant's proposed rates or the applicant's ability to underwrite insurance using the proposed risk classification system.

**PART XVIII
UNFAIR AND DECEPTIVE ACTS AND
PRACTICES IN THE BUSINESS OF INSURANCE**

Definitions

438. For the purposes of this Part,

...
"unfair or deceptive acts or practices" includes,
 (a) the commission of any act prohibited under this Act or the regulations,
 (b) any unfair discrimination between individuals of the same class and of the same expectation of life, in the amount or payment or return of premiums, or rates charged by it for contracts of life insurance or annuity contracts, or in the dividends or other benefits payable thereon or in the terms and conditions thereof,
 (c) any unfair discrimination in any rate or schedule of rates between risks in Ontario of essentially the same physical hazards in the same territorial classification,
...

Prohibition

439. No person shall engage in any unfair or deceptive act or practice. R.S.O. 1990, c. I.8, s. 439.

Superintendent may investigate

440. The Superintendent may examine and investigate the affairs of every person engaged in the business of insurance in Ontario in order to determine whether such person has been, or is, engaged in any unfair or deceptive act or practice. R.S.O. 1990, c. I.8, s. 440.

EMPLOYMENT STANDARDS ACT

PART X BENEFIT PLANS

No differentiation because of age, etc.

33. (2) Except as provided in the regulations, no employer or person acting directly on behalf of an employer shall provide, furnish or offer any fund, plan, arrangement or benefit that differentiates or makes any distinction, exclusion or preference between employees or a class or classes of employees or their beneficiaries, survivors or dependants because of the age, sex or marital status of the employees.

Powers of Director

33. (4) Where, in the opinion of the Director, an employer, an organization of employers or employees or a person acting directly on behalf of an employer or such organization may have acted contrary to subsection (2), the Director may exercise the power conferred by subsection 69 (1), and section 69 applies with necessary modifications.

Regulations

33.(5) In addition to the powers conferred by section 84, the Lieutenant Governor in Council may make regulations respecting any matter or thing necessary or advisable to carry out the intent and purpose of this Part,

Reg.321(8)

The prohibition in subsection 33 (2) of the Act does not apply to,

(c) the exclusion from benefits under a short or long term disability insurance plan of a female employee during the period of leave-of-absence to which she is entitled under Part XI of the Act, or any greater period of leave-of-absence that she has applied for under any term of a contract of employment, oral or written, express or implied, that prevails over Part XI of the Act. R.R.O. 1990, Reg. 321, s. 8.

PART XI PREGNANCY AND PARENTAL LEAVE

Rights during leave

42. (1) During pregnancy leave or parental leave, an employee continues to participate in each type of benefit plan described in subsection (2) that is related to his or her employment unless he or she elects in writing not to do so.
- (2) For the purpose of subsection (1), the types of plans are pension plans, life insurance plans, accidental death plans, extended health plans, dental plans and any other type of benefit plans that are prescribed.
- (3) During an employee's pregnancy leave or parental leave, the employer shall continue to make the employer's contributions for any plan described in subsection (2) unless the employee gives the employer a written notice that the employee does not intend to pay the employee's contributions, if any.
- (4) Seniority continues to accrue during pregnancy or parental leave. 1990, c. 26, s. 2, part.

Employment standards officer may make order

45. When an employer fails to comply with the provisions of this Part, an employment standards officer may order what action, if any, the employer shall take or what the employer shall refrain from doing in order to constitute compliance with this Part and may order what compensation shall be paid by the employer to the Director in trust for the employee. R.S.O. 1980, c. 137, s. 39

**OHRC LETTER TO THE FORMER ONTARIO
INSURANCE COMMISSION**

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Toronto, Ontario
M7A 2R9

**Public Policy &
Public Education Branch**
(416) 314-4524

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**Direction des politiques
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November 28, 1997

Hearings Assistant
Ontario Insurance Commission
5160 Yonge Street, Box 85
North York ON M2N 6L9

In accordance with PART IV, s.36 of the Ontario Insurance Commission's ("the OIC") *Rules of Practice and Procedure for Commissioner, Superintendent and Advisory Board Hearings*, the Ontario Human Rights Commission ("the Commission") submits this *letter of comment* with respect to the public hearing to be held on an application filed by (the insurer) for an automobile insurance classification system and automobile insurance rates.

The Commission has reviewed both the application filed by (the insurer) as well as the *Final Report* on this matter prepared by the OIC. The following comments are with respect to those elements of the proposed risk classification system that appear to have social policy implications.

Certain risk classification factors under (the insurer) proposed system, namely: credit card ownership, bankruptcy status, employment status and stability, and residence status and stability, might be found to contravene Part I of the Ontario *Human Rights Code*.

Upon reading of (the insurer's) broker manual, it might be argued that an individual, as the named insured, who is single (without a spouse) and who does not meet some or all of the above risk criteria in the cascade of market classes could be discriminated against on the ground of marital status. This would occur when comparing such an individual to another individual who also does not meet the same risk criteria, but who has a spouse, and that spouse does meet some or all of the risk criteria.

Conversely, an individual with a spouse may be negatively affected if the spouse does not meet one of the risk criteria such as having a bankruptcy-free status.

Furthermore, it might be argued that the exclusion from the range of “preferred” discounted markets of individuals who do not meet some or all of the risk criteria “results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination”, in contravention of section 11 of the *Code*. For example, it might be statistically shown that women as a group are less likely than men to be homeowners, credit card holders or employed. Two-year residence status might discriminate against recent immigrants. Non-student status might discriminate against youth.

It is conceivable that based on one of the above scenarios a named insured might file a complaint of discrimination with the Commission in the area of services or contracts on related grounds in the *Code* such as marital status, sex or place of origin. If the proposed risk classification system was found to be discriminatory under the *Code*, it would then have to be determined if such discrimination would be considered “reasonable” and “*bona fide*” on the basis of the grounds under section 22.

Section 22 of the *Code* provides that individual and group insurance policies, not part of an employment relationship, may make distinctions based on age, sex, marital and family status, or handicap, but these distinctions must be made on reasonable and *bona fide* grounds.

The Supreme Court of Canada in *Zurich Insurance Co. v. Ontario (Human Rights Comm.)* (1992), 16 C.H.R.R. D/255 (S.C.C.) defined a practice as *bona fide* if it was adopted honestly, in the interests of sound and accepted business practice and not for the purpose of defeating the rights protected under the *Code*. The Court held that a discriminatory practice is “reasonable” if:

- It is based on a sound and accepted insurance practice; and
- There is no practical alternative.

A sound and accepted insurance practice was defined as one that is adopted “for the purpose of achieving the legitimate business objective of charging premiums that are commensurate with risk”.

It is unclear whether a Board of Inquiry or a Court would find that (the insurer’s) proposed risk classification system “is based on a sound and accepted insurance practice” as was found in *Zurich*. The OIC as the body responsible for the *Insurance Act* would have to provide its expert opinion on whether the insurer’s proposal, including actuarial analysis, is based on a *bona fide* business practice. The OIC’s *Final Report* acknowledges that “(the insurer) has presented evidence of a statistical correlation between these (risk classification) factors and loss experience”.

It is also questionable whether it would be found that “there is no practical alternative” to (the insurer’s) proposal. The Supreme Court clearly stated that the insurance industry should be actively working to develop non-discriminatory criteria for assessing risk. To date, the industry has not developed such a new system for automobile insurance. A

similar automobile insurance complaint may, therefore, be decided quite differently today.

The *Zurich* decision means on the one hand that the insurance industry can contravene certain grounds under Part I of the *Code* if it can show under section 22 that such a practice is adopted “for the purpose of achieving the legitimate business objective of charging premiums that are commensurate with risk”. At the same time, the Court made it clear that the insurance industry should not continue indefinitely to use discriminatory criteria for rate setting and stated that “the industry must strive to avoid setting premiums based on enumerated grounds”. When these two aspects of the *Zurich* decision are read together, it might be argued that any newly proposed classification system, even if shown to be a better measure of risk, should at least not further contravene Part I of the *Code* any more than any current classification system does. And in fact, such a newly proposed system should strive to avoid determining risk based on enumerated grounds.

Irrespective of the majority decision in *Zurich* and the section 22 exception under the *Code*, the OIC appears to apply a different interpretation of what is a “reasonable” and *bona fide* risk classification variable.

The OIC argues a similar contention to the opinion of the two dissenting judges in the *Zurich* case. The judges found that a statistical correlation is not sufficient to justify the reasonableness of a discriminatory practice. There must be a causal connection.

In its *Final Report* response to (the insurer’s) application, the OIC states (p.5-6) that any new risk classification variable must pass all tests set out in the *Insurance Act* (section 412.1 in particular). It goes on to say that apart from a statistical relationship, the risk classification variable must also make a fair distinction. Furthermore:

One indicator of the reasonableness of a risk classification system is its causality, i.e. the insured should be able to logically deduce how they are being rated and see the effect that their driving characteristics has on their rate (OIC *Final Report*, p.7).

The majority decision in *Zurich* does not rely on a “causal connection” but simply a statistical correlation as sufficient to justify the reasonableness of a discriminatory business practice. The OIC’s position that an insured motorist should be able to see how their driving affects their insurance rate thus appears to be a more stringent test of “reasonableness” than found in the *Zurich* interpretation of section 22 of the *Code*. Under the *Insurance Act*, the Commissioner of Insurance has the authority to prescribe through regulation elements and conditions of a risk classification system.

An automobile insurance complaint today similar to that in *Zurich* might be decided differently in that a Board of Inquiry or Court could take into account the OIC’s position that there should be a causal connection between risk classification and driving characteristics and that the *Insurance Act* gives the Commissioner of Insurance the discretion to require such a condition.

Finally, (the insurer's) broker manual reference to fraud conviction in relation to auto insurance as an unacceptable risk should be qualified with the statement "for which a pardon has not been granted" pursuant to section 10(1) of the *Code*.

Please note that the above comments are an opinion of the Commission only and will not preclude the Commission from inquiring into any matter that may be brought to its attention under the *Code*.

The Commission is available to meet with the OIC to discuss this matter further. You may contact me at 416-314-4522.

Sincerely,

ORIGINAL
SIGNED BY

F. Pearl Eliadis
Director

CASE SUMMARIES
(Extracts from CHRR)

DISCRIMINATORY AUTO INSURANCE RATES ALLOWED FOR *BONA FIDE* REASONS

***Zurich Insurance Co. v. Ontario (Human Rights Comm.)*
(1992), 16 C.H.R.R. D/255 (S.C.C.) [ENG/FR. 46 PP.]**

The majority of the Supreme Court of Canada finds that Zurich Insurance did not discriminate against Michael Bates contrary to the Ontario Human Rights Code by charging him higher premiums for automobile insurance because of his age, sex, and marital status.

In 1983 Michael Bates alleged that he was discriminated against because Zurich Insurance charged him higher premiums for his automobile insurance than a young, single, female driver with the same driving record, or than drivers over age 25. He alleged that the rate classification system discriminated by grouping drivers by age, sex, and marital status and determining their premiums based on these factors.

The majority of the Supreme Court of Canada finds that charging higher automobile insurance premiums to young, unmarried, male drivers is prima facie discriminatory and contravenes the Ontario Human Rights Code. However, the issue in this appeal is whether that discrimination is permitted by virtue of s. 21 of the Code. Section 21 states that the prohibitions against discrimination are not infringed where a contract of automobile insurance differentiates on reasonable and bona fide grounds because of age, sex, marital status, family status or handicap.

The Board of Inquiry which originally heard Michael Bates' complaint concluded that Mr. Bates was discriminated against because the insurer could not establish that not using the rates based on discriminatory criteria would undermine the essence of the business.

On appeal, the Ontario Divisional Court overturned this decision. It concluded that the Board of Inquiry had applied the wrong test and that the words "reasonable and bona fide" found in s. 21 should be given their plain meaning. It ruled that at the relevant time no other statistical data was available on which to base the risk classification of automobile drivers and that consequently there were reasonable and bona fide grounds to rely on the statistics that were available.

This decision was upheld by the Ontario Court of Appeal.

The majority of the Supreme Court of Canada in a decision written by Mr. Justice Sopinka finds that the test in s. 21 is whether (a) a discriminatory practice is based on sound and accepted insurance practices and (b) there is no practical alternative.

The majority finds that the premiums were based on sound and accepted insurance practices. Statistical evidence shows that young, male drivers are involved in proportionately more, and more serious, accidents than other drivers.

However, the fact that there is a statistical correlation between age, sex and marital status, and insurance losses does not fully satisfy s. 21. Human rights values cannot be overridden by business expediency alone. To allow discrimination simply on the basis of statistical averages would only serve to perpetuate traditional stereotypes with all their invidious prejudices. It is necessary therefore to consider whether there is a practical alternative in the circumstances.

The majority finds that there was no practical alternative. Alternative statistical bases of risk classification were not available at the time. The Superintendent of Insurance requires reporting based on certain criteria, but at the time of the complaint statistical data was not available to support classification based on other relevant, non-discriminatory criteria.

The appeal is dismissed.

In a dissenting judgment, Madam Justice L'Heureux-Dubé disagrees with the majority regarding the appropriate test to be applied under s. 21. She concludes that the appropriate test of whether there are reasonable and bona fide grounds for a distinction in premiums based on age, sex, and marital status should be similar to the test set out in *Brossard*. Following *Brossard*, the distinction must be:

imposed honestly, and in the sincerely held belief that it accurately reflects the cost of the risk insured;

based on a rational, that is a causal, connection between the distinction and the insured risk; and

a reasonable means of identifying and classifying similar risks.

L'Heureux-Dubé finds that the discriminatory classification scheme was imposed in good faith. However, she finds that there is no causal connection established between being young, single and male and being a higher risk with respect to automobile safety. A mere statistical correlation is not satisfactory, because it accepts the very stereotyping that is deemed unacceptable by human rights legislation.

Age, sex, and marital status have never been controlled or isolated in the statistics used by insurers to determine whether there is a causal connection. The insurance industry has attempted to bridge this gap in its knowledge by reliance on myth and stereotype. This does not satisfy the burden of proof.

In addition, L'Heureux-Dubé finds that there was a reasonable alternative means available to the insurer. It set rates for drivers over 25 years of age based on individual accident records and distance driven. There is no evidence to indicate that the same criteria could not be used for rate classification for drivers 25 and under.

For these reason, L'Heureux-Dubé finds that Zurich Insurance has not satisfied the requirements of s. 21 of the Ontario Human Rights Code. She would allow the appeal.

In her dissenting judgment Madam Justice McLachlin agrees with the majority regarding the test to be applied, but concurs with L'Heureux-Dubé regarding the result.

She finds that Zurich Insurance has failed to prove that there was no practical alternative to using discriminatory criteria as the basis for rate classification. The fact that Zurich Insurance cannot prove that there is no practical alternative does not mean that there is no practical alternative. It cannot prove that there is no practical alternative because it does not have the statistical data necessary to do so. The absence of evidence of alternatives must not be confused with an absence of alternatives. The insurer bears the burden of showing that no reasonable alternative exists, and through its own failure to collect the required data it has failed to meet the burden. That it does not know if there is a practical alternative is not a defence.

Madam Justice McLachlin finds that Zurich Insurance has not discharged the onus of proof on it. She would allow the appeal.

Thornton v. North American Life Assurance Co.
(No.5) (1992), 17 C.H.R.R. D/481 (Ont. Board Inq.)

In this case, the complainant alleged discrimination based on handicap as a result of an exclusion clause in a long-term disability plan offered by his employer. The exclusion clause in that plan prohibited employees from receiving long term disability benefits if the employee received care or treatment by a physician in the 90 day period prior to the date the insurance became effective. The complainant had visited his physician twice in the first 90 days of his employment in order to discuss his HIV positive status. Eleven months into his employment Mr. Thornton applied for long-term disability benefits because of an illness related to his HIV status.

The Board of Inquiry dismissed the complaint.

Ontario (Human Rights Comm.) v. North American Life Assurance Co.
(1995), 23 C.H.R.R. D/1

In March 1995, the Ontario Divisional Court dismissed an appeal by the Ontario Human Rights Commission and Gary Thornton from the 1992 Board of Inquiry decision. The Divisional Court found no error in the Board of Inquiry's interpretation of section 25(3)(a) and found that Mr. Thornton's HIV status would have substantially increased the risk under the plan and that the rejection of his claim did not violate the *Code* (CHRR summary).

**LIMITATION OF BENEFITS TO THE MENTALLY DISABLED
DISCRIMINATORY**

***Gibbs v. Battlefords and Dist. Co-operative Ltd.*
(1996), 27 C.H.R.R. D/87 (S.C.C.)**

The Supreme Court of Canada dismisses an appeal by Battlefords and District Co-operative Limited from a decision of the Saskatchewan Court of Appeal. The Court of Appeal upheld a Board of Inquiry ruling that the Co-operative discriminated against Betty-Lu Clara Gibbs on the ground of mental disability because of the terms of an employment-related insurance plan.

Ms. Gibbs is an employee of the Battlefords and District Co-operative Limited. She became disabled in 1987 as a result of a mental disorder and was unable to work. Ms. Gibbs used up her sick leave, and then was paid benefits under an insurance policy that was part of the benefit package provided to employees pursuant to their collective agreement.

Under the terms of the policy, any employee who became unable to work was provided with replacement income for as long as the disability prevented the employee from working or until age 65. However, if the disability in question was a mental disability, the replacement income would terminate after two years, even if the person was unable to resume employment, unless the employee remained in a mental institution. Because of this provision, Ms. Gibbs' insurance benefits were terminated in March 1990. Had her disability been physical in nature, the benefits would have continued until age 65 whether or not Ms. Gibbs was in an institution.

The issue in this appeal is: does the Co-operative's disability plan, which places limitations on benefits for mental disability, but not for other kinds of disability, discriminate on the basis of disability contrary to s. 16(1) of The Saskatchewan Human Rights Subscriptions?

The Co-operative argues that there was no discrimination based on mental disability, since the relevant term or condition of employment was an entitlement to insurance benefits under the policy, which all employees received equally. Given the contingent nature of insurance, when the contract was entered into each insured employee enjoyed exactly the same protection from the harm of future disability.

Sopinka J., writing for the Court, rejects this argument. He finds that while each employee enjoyed the same "peace of mind" from the insurance before any risk materialized, the insurance plan also provided a significant benefit to employees after the risk of disability materialized and this benefit was not distributed equally. Those with mental disabilities received less than those with physical disabilities. It would be inimical to the objects of human rights legislation if a practice could be immunized from scrutiny under this legislation simply because its discriminatory effects are contingent on

uncertain future events. In Ms. Gibbs' case, the discrimination was deferred until she became vulnerable and most in need of human rights protection.

The Co-operative also argues that the insurance plan should not be viewed as discriminatory since the appropriate comparison is not between the mentally disabled and the physically disabled but rather between the disabled generally and the able-bodied. The purpose of the Subscriptions is to prevent discrimination against the disabled as compared to able-bodied persons, not as compared to other disabled persons.

The Court also rejects this argument. The "mental disability-physical disability" comparison is appropriate. First of all, to find that there is discrimination on the basis of disability it is not necessary to find that all disabled persons are mistreated equally. It is not fatal to a finding of discrimination that not all persons in the group bearing the relevant characteristic have been discriminated against. Discrimination against a subset of the group, in this case those with a mental disability, can be considered discrimination against persons with disabilities.

In addition, if the comparator group is all persons without a disability, a claim of discrimination on the basis of inadequate disability insurance benefits is not likely to be successful. Such a result seems contrary to the purpose of human rights legislation, especially given the particular historical disadvantage facing mentally disabled persons.

In this case, the insurance plan was designed to insure employees against the income-related consequences of becoming disabled and unable to work. The benefits for those with mental disabilities and those with physical disabilities were designed for the same purpose: to insure against the income-related consequences of being unable to work because of disability. Consequently, it is appropriate to compare the benefits available to those with mental disabilities to the benefits available to those with physical disabilities. The true character or under-lying rationale of the insurance plan was to provide income replacement for those unable to work because of disability, and consequently limiting benefits on the basis of mental disability are discriminatory.

The Court also finds that the insurance context which was relevant in *Zurich Insurance Co. v. Ontario (Human Rights Comm.)* is not relevant here. In *Zurich* the company led evidence to show that there was a justification for the discrimination in its automobile insurance scheme because it would have been impractical to base the calculation of the risk of accidents on any other data than that related to sex and age. In this case, the limit on benefits available to a mentally disabled employee unless he or she is institutionalized appears to be grounded on a stereotypical assumption concerning the behaviour of mentally disabled persons.

The appeal is dismissed.

In a separate judgment, McLachlin J., who agrees with Sopinka J. regarding the outcome, states her concerns with respect to the formulation of the purpose test.

Under the proposed test, discrimination is determined by examining the true purpose of the insurance plan. Discrimination will exist if benefits received for the same purpose differ on the basis of a characteristic not relevant to the purpose of the insurance scheme. In the instant case, the defined purpose of the scheme is to insure employees against the income-related consequences of becoming disabled and unable to work. When the purpose is framed broadly with reference to the need which the plan seeks to address and without reference to specific injuries or specific groups of people, the nature of the disability becomes an irrelevant characteristic. Therefore, to distinguish benefits on the basis of disability constitutes discrimination.

However, if it is open to the employer and employee to define the purpose of a benefit narrowly by reference to a target group, like alcoholics, as Sopinka J. suggests it would be in his judgment, the result may be to condone exclusion of many valid claims and permit de facto discrimination against others similarly disabled from other causes. McLachlin J. concludes that in defining the purpose of schemes, reference should not be made to specific disabilities and specific target groups, but rather to the broad purposes. Subject to these concerns, she agrees with the judgment of Sopinka J.

RESTRICTIONS ON BENEFITS ON THE BASIS OF SEXUAL ORIENTATION DISCRIMINATORY

***Dwyer v. Toronto (Metro)*
(NO. 3) (1996), 27 C.H.R.R. D/108 (ONT. BD.INQ.) [ENG. 32 PP.]**

William Dwyer and Mary-Woo Sims allege that the Municipality of Metro Toronto discriminates against lesbian and gay employees who have partners of the same-sex with respect to three categories of employment benefits: uninsured benefits (such as leave to care for ill dependents); insured benefits (such as extended health); and survivor pension entitlement. They assert that this discrimination with respect to benefits contravenes the Ontario Human Rights Code and the Canadian Charter of Rights and Freedoms.

Though Metro Toronto argues that in practice uninsured benefits, such as bereavement leave and leave to care for ill dependents, are granted on a discretionary basis to lesbian and gay employees to mourn for or take care of persons with whom they are intimate, the collective agreement with CUPE, Local 79 and Metro personnel policies do not acknowledge the family relationships of employees in same-sex relationships and no formal written direction has been given to managers that same-sex relationships are covered.

CUMBA is the insurer and administrator of the various medical benefit plans at Metro. The major insured benefits include comprehensive medical benefits (e.g. drugs, glasses, orthopedic shoes, chiropractor, basic and orthodontic dental plan). Group life and long term disability are also provided, though those plans are administered by different insurance carriers. These benefits are commonly considered a part of the total wage package of employees.

Since 1992, Metro has provided insured benefits in respect of same-sex relationships. However, it does so on an "interim" basis because the definition of "spouse" in the Municipal Act does not authorize the provision of extended health benefits to same-sex partners. In 1992 the Metro Council requested the provincial government to amend the definition of "spouse" in the Act to provide the appropriate authority, but this amendment has not been made.

Also Metro employees receive pension benefits through the Ontario Municipal Employees Retirement System (OMERS). OMERS is one of the largest retirement plans in the country. It includes over 1,100 municipalities providing pension benefits to approximately 200,000 employees and 60,000 pensioners. The same-sex partners of Metro employees are not entitled to survivor pensions under the terms of the OMERS plan. Eligible spouses are the opposite-sex partners of employees, either married or common law.

Pensions are commonly recognized as a form of employee compensation, in effect, as deferred wages. There are various types of pension plans, but the federal Income Tax Act ("ITA") sets out the framework for registration of pension plans. Significant tax

advantages flow from registration under the ITA. Employee contributions (within the limits prescribed) are tax deductible; the investment earnings of the pension fund are tax sheltered until pay-out; the employer contributions are not a taxable benefit to employees at the time the contributions are made. However, the ITA has an opposite-sex definition of "spouse" in respect of pension plans (though both married and common law spouses are included) and does not permit the payment of survivor benefits to a same-sex partner. A pension plan which provides such benefits is subject to deregistration under the ITA and the loss of significant tax advantages. The Ontario Pensions Benefit Act ("PBA"), which requires that pension plans in Ontario conform with it and be registered with the Pension Commission, also defines "spouse" to include only opposite-sex partners. Since 1988, the PBA has required that pension plans provide benefits for surviving spouses in the form of a lump sum death benefit or a survivor pension.

As a result of these various legislative provisions regarding pensions, currently a same-sex spouse has no status comparable to an opposite-sex spouse and is not entitled to a survivor pension. A same-sex partner may be eligible for a lump sum death benefit if he or she is named as beneficiary in the pension plan. But as the beneficiary not the "spouse", the same-sex partner will have to pay tax immediately on the lump sum death benefit because the tax shelters of the ITA are provided only to recognized "spouses". A recognized spouse is entitled to "roll over" the funds so that the monies are tax sheltered until they are paid out.

Since the consequences of deregistration of a plan if same-sex survivor pensions are provided are drastic, alternative "off-side" arrangements have been designed by some employers to provide survivor benefits to same-sex partners. A Registered Compensation Arrangement ("RCA") is an "off-side" plan funded outside the regular pension plan. It operates like a registered pension plan but without the significant tax advantages to the employee and the employer. Also, the applicable tax rates produce a net effect of halving the investment return. Consequently, there is a significantly higher level of contributions required to produce a comparable level of benefits.

The Board of Inquiry finds that it has the authority to consider the constitutionality of its enabling statute, the Ontario Human Rights Code. It is also appropriate for it to consider the constitutionality of the other pieces of legislation which are directly linked to this complaint, including the PBA, the Municipal Act and the Municipality of Metropolitan Toronto Act. An administrative tribunal may address a Charter issue if it has jurisdiction over the whole matter before it, namely, the parties, the subject-matter and remedies sought, although the tribunal may only treat an impugned provision as invalid for the purposes of the matter before it and cannot issue a formal declaration of invalidity.

The issue here is whether the practice of denying equality in benefits to the same-sex partners of Metro employees contravenes s. 15 of the Charter which, the Supreme Court of Canada has ruled, prohibits discrimination based on sexual orientation. The Ontario Human Rights Code prohibits discrimination on the basis of sexual orientation but it still contains an opposite-sex definition of "spouse" and "marital status". Section 10

of the Code defines marital status as "the status of being married, single, widowed, divorced or separated and includes the status of living with a person of the opposite-sex in a conjugal relationship outside marriage". The other legislation that is implicated here contains similar definitions. Before the Board of Inquiry are these questions: (1) do opposite-sex definitions of spouse and marital status violate s. 15 of the Charter when they are applied to justify the refusal of employment-related benefits to the same-sex partners of Metro; (2) can this discrimination be justified as a reasonable limit pursuant to s. 1 of the Charter.

Since the respondents concede that the benefit schemes discriminate on the basis of sexual orientation, the Board of Inquiry proceeds directly to consider the question of whether the discrimination is justified as a reasonable limit pursuant to s. 1.

The respondents argue that the restriction of insured benefits and pension benefits to opposite-sex partners reflects: an incremental approach to expanding protection against discrimination; concern with the additional costs and administrative burden; support for couples with capacity to procreate and which generally raise children in society; legislative consistency with other provincial statutes and with the ITA. The Board of Inquiry finds that the evidence is questionable as to the objectives of the legislation beyond a desire to provide benefits to female spouses in traditional family units where the husband worked outside the home and the wife raised the children and was economically dependent. The Board of Inquiry accepts this as a valid legislative objective.

However, the Board of Inquiry finds that the means chosen to achieve the legislative objective is to allow discrimination with impunity against the same-sex spouses of employees. There is no rational connection between a desire to extend employment benefits to wives or women in general and an opposite-sex definition of "spouse". The statutory language is neutral; the benefits apply equally to the husbands of female employees. The provision is not related to financial need or economic dependency; the benefits are extended where both husband and wife are employees and/or are financially secure. At the same time same-sex partners are totally denied benefits even if their relationships reflect economic dependency and financial need – the very concerns of the legislation. Finally, there is not a proportionality between the effects of the measures (the denial of benefits to same-sex spouses) and the objective of ameliorating female poverty.

The Board of Inquiry considers the decision of the Supreme Court of Canada in *Egan v. Canada*, which found that, although it was discrimination to deny spousal benefits under the Canada Pension Plan to same-sex partners, this discrimination was a reasonable limit that was justifiable pursuant to s. 1. However, it distinguishes the decision from the matter before it because the Supreme Court of Canada was dealing with social benefits not employment benefits. The Board of Inquiry finds that a stricter application of s. 1 criteria is necessary where an individual's earnings are involved and the discrimination results in the unequal treatment of employees solely because of the sex of their spouses.

The Board of Inquiry concludes that the equality guarantees in s. 15 of the Charter are contravened by the opposite-sex definitions of spouse and marital status in the Code and related legislation regarding the employment benefits in question in these complaints. The opposite-sex definitions in the legislation constitute discrimination based on sexual orientation. The offending provisions are not saved by s. 1 as limitations demonstrably justified in a free and democratic society.

Considering remedies, the Board of Inquiry concludes that with respect to pension benefits the stumbling block to equality for same-sex spouses is the opposite-sex definition in the ITA. That is beyond the jurisdiction of the Board of Inquiry to address since the ITA is federal legislation. The Board of Inquiry is not convinced that requiring the establishment of an "off-side" arrangement for pension benefits is appropriate in all the circumstances. However, once the ITA permits the benefits to be extended without deregistration of the pension plans, the benefits should be provided to same-sex partners.

The Board of Inquiry orders that:

1. The definitions of "spouse" and "marital status" in s. 10 of the Code are to be read down so as to eliminate the discriminatory effect of the words "of the opposite-sex".
2. The opposite-sex definitions of "spouse" in the Municipal Act and the Municipality of Metropolitan Toronto Act are to be read down in connection with the authority of municipalities to enter into contracts to provide insured benefits (including health plans) for their employees, their spouses, and children.
3. The Province is to interpret and apply the Municipal Act definition of spouse as if it included same-sex spouses with respect to insured benefits and uninsured benefits, and to apply this to pension benefits as well once the definition of spouse is changed in the ITA. The Province is ordered to advise all municipalities of this interpretation within a reasonable time.
4. Metro is to continue providing insured benefits to same-sex spouses on the same basis as such benefits are provided to opposite-sex spouses.
5. The opposite-sex definitions in the PBA (and related provisions in the OMERS Act and the provincial ITA) are to be read down so that same-sex spouses are not excluded once the federal ITA permits pension benefits to be extended without deregistration of the pension plans.
6. Metro is to provide uninsured benefits without discrimination on the basis of the sex of the spouses of its employees, and to take the necessary steps to inform its managers and employees of their entitlement to such benefits. Metro and CUPE, Local 79 are directed to enter into a Letter of Understanding which clarifies the entitlement of same-sex spouses to uninsured benefits under the collective agreement.
7. Metro is ordered to pay Mr. Dwyer the sum of \$10,000 as general damages and \$1,200 for expenses which he incurred because of the discrimination. Metro is also ordered to pay Ms. Sims \$4,000 as general damages.

SEX DISCRIMINATION INCLUDES PREGNANCY

***Brooks v. Canada Safeway Ltd.*
(1989), 10 C.H.R.R. D/6183 (S.C.C.) [ENG./FR. 23 PP.]**

The Supreme Court, in a unanimous decision, rules that Safeway's employee disability plan discriminated against pregnant employees and that this constitutes discrimination because of sex within the meaning of s. 6(1) of the 1974 Manitoba Human Rights Act.

This is an appeal from a decision of the Manitoba Court of Appeal which found that the Safeway disability plan did not discriminate against pregnant employees and that discrimination because of pregnancy is not discrimination because of sex.

The Safeway disability plan, which was challenged in the complaints of Susan Brooks, Patricia Allen and Patricia Dixon, provided twenty-six weeks of disability benefits to any worker who had worked for Safeway for three months and who had to be absent from work for health reasons. However, the plan denied benefits to pregnant employees during a seventeen-week period commencing ten weeks before the week of childbirth and extending to six weeks after it. During this time, pregnant employees who were unable to work, either because of pregnancy-related complications or non-pregnancy-related illness, were not eligible for benefits. UIC maternity benefits provided an imperfect substitute for the disability benefits because they required a longer work period for eligibility, and provided less money for a shorter time.

The Court finds that pregnancy provides a perfectly legitimate health-related reason for not working and as such it should be compensated under the Safeway plan. Not to compensate pregnant employees for legitimate health-related absences goes against the purpose of human rights legislation which is to remove unfair disadvantages suffered by groups. Though society in general benefits from procreation, the Safeway plan places the major costs of procreation entirely on one group – pregnant women -- and imposes unfair disadvantages on them.

Having found that the plan discriminated against pregnant employees, the Court considers the second issue in this appeal: whether discrimination because of pregnancy is discrimination because of sex. The Manitoba Court of Appeal relied on the 1979 Supreme Court of Canada decision in *Bliss v. Canada (Attorney General)* to support its finding that discrimination because of pregnancy is not discrimination because of sex because not all women are or become pregnant.

The Supreme Court repudiates *Bliss*, stating that *Bliss* was decided wrongly or in any case would not be decided now as it was then. The reasoning of *Bliss* and the Manitoba Court of Appeal decision in this case are rejected; the fact that only some women are affected by pregnancy-related discrimination does not mean that it is not discrimination because of sex. Only women are affected by this form of discrimination and they are discriminated against because of their gender.

The Court concludes that Safeway's disability plan discriminated against pregnant employees because of their sex.

The Court sets aside the decision of the Manitoba Court of Appeal with costs of the proceedings before the Manitoba courts and the Supreme Court and remits the complaints to the Board of Adjudication for determination of the appropriate remedy.

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** Unedited **

Indexed as:

Kane v. Ontario (Attorney-General)

Between

Kelly Kane, and

The Attorney-General for Ontario, and Her Majesty the Queen,
in Right of Ontario, as represented by the Minister of Finance
and Axa Insurance Co.

[1997] O.J. No. 3979

DRS 97-14399

No. RE 6451/96

Ontario Court of Justice (General Division)

Coo J.

Heard: September 23, 1997.

Judgment: October 1, 1997.

(6 pp.)

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Civil rights -- Discrimination -- Sexual orientation --
Homosexuals -- Equality and protection of the law -- Particular
cases -- Insurance legislation -- Canadian Charter of Rights
and Freedoms -- Denial of rights -- Remedies, declaration of
invalidity of statute.

Application for a declaration that the definition of spouse
in the Ontario Insurance Act was unconstitutional. Kane was in
a long-lasting same-sex relationship with a woman who was
killed in a motor vehicle accident. Kane's claim for benefits
on the relevant policy was denied since the relationship was
same-sex. Spouse was defined in section 224(1) of the Act as
either of "a man and a woman" in certain designated
relationships. Kane claimed that this definition of spouse, as
it affected her right to claim a death benefit under the No-
Fault Benefits Schedule, was unconstitutional.

HELD: Application allowed. Section 224(1) was
discriminatory contrary to section 15 of the Canadian Charter
of Rights and Freedoms and was not saved by section 1. The
denial of equal benefit in the legislation was deliberately
based on sexual orientation and ran against the preservation of

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human dignity and self-worth for part of our society. The
section was unconstitutional insofar as it provided a limiting
definition of spouse which should be altered to read "either of
two persons". Kane was accordingly awarded judgment of the
\$25,000 death benefit.

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Note: Unreported decision, cited in *Quicklaw*