1st International Conference of the Jean Monnet Module EU Insurance Law: **Challenges in the SDG Era**

SDG 3: Good Health and Well-being

2023

Scientific Coordinators and Editors
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1st International Conference of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era. SDG 3: Good Health and Well-being

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PUBLISHER:
NOVA School of Law, NOVA University, Lisbon
CEDIS, Centro de I & D sobre Direito e Sociedade
Campus de Campolide, 1099-032 Lisbon, Portugal

Digital edition

December 2023

ISSN 2976-0046

CITATION
Rego, Margarida Lima/ Bolivar Oñoro, Maria del Val/ Ramos, Maria Elisabete (ed.). 1st International Conference of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era. SDG 3: Good Health and Well-being. Lisbon: CEDIS, 2023

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Introduction

1. The 1st International Conference of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era – SDG 3: Good Health and Well-being: Overall Purpose

This Conference forms part of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era (ref. no. 101085125), funded by the European Union (Erasmus+ Programme). The main objective of this annual conference was to create a forum where scholars, practitioners, non-governmental organizations, third sector, and state agencies with an interest in insurance met and discussed topics that are of interest to all, with a focus on public policy recommendations: the role of insurance in fostering sustainable development goals. It was aimed at contributing to the generation of knowledge and raising awareness as to the role of insurance for the equal enjoyment of Human Rights and the achievement of SDGs, in line with the core values of the European Union.

2. Coordinators and Scientific Committee

The scientific coordinators of the conference and editors of these proceedings were Prof. Margarida Lima Rego, Prof. María del Val Bolívar Oñoro, and Prof. Maria Elisabete Ramos. Additionally, the scientific committee was composed of Prof. Claire Bright, Prof. Fabrizio Esposito, Prof. Joana Campos Carvalho, Prof. Soraya Nour-Sckell, Ph.D. candidates Martinho Lucas Pires, Patrícia Assunção Soares, and Vítor Boaventura Xavier

3. The call for papers

A call for papers was launched in January 2022, welcoming abstracts related to the conference's main topic. All abstracts were assessed by the conference coordinators and members of the scientific committee, based on the originality and innovative nature of the work, relevance to the conference topic, and diversity.

A few abstracts were presented, but only three were accepted. Due to unforeseen circumstances, one submission was dropped near the date of the Conference. Therefore, only two scientific communications were presented at the event. The respective slide presentations are included in these proceedings.

The possibility of applying for the Conference Prize was announced on the same call. The prize was aimed at young scholars, including Ph.D. candidates and holders of a Ph.D. who successfully defended their theses less than five years before the date of the conference. The prize was 500€ and a certificate. In this first conference, it was decided by the coordinators and scientific committee members that the only submission that met the formal application criteria did not reach the standards required to win the prize. Therefore, no prize was awarded.

4. The Conference: Programme and Participants

The main conference followed a hybrid format, the venue being at NOVA School of Law in Lisbon. The conference took place on 13 July 2023. Works representing all sections of the conference are published in these proceedings.

The opening ceremony was chaired by Prof. Margarida Lima Rego, Dean of NOVA School of Law and Coordinator of the Jean Monnet Module. The main speakers were Margarida Corrêa de Aguiar, President of the Portuguese Insurance and Pension Funds Supervisory Authority (ASF), and Prof. Cláudio Soares, NOVA University Pro-Rector and Coordinator of the NOVA Health Platform.

The first keynote speaker was Prof. Pedro Pita Barros, BPI, and La Caixa Foundation Chair Professor in Health Economics and Head of the Health Economics & Management Knowledge Center at Nova School of Business and Economics. His topic was “The role of insurance in the healthcare sector: some data”.

After this intervention, the first roundtable was hosted. It was composed of Prof. Angélica Carlini (UNIMES and member of AIDA Brazil), Prof. Marival Bolívar Oñoro (Univ. Alcala and member of AIDA Spain), and Prof. Margarida Lima Rego (NOVA School of Law and President of AIDA Portugal). The topic was "International perspectives. The role of public policy" and it was moderated by Prof. Sónia Dias (Dean of the NOVA National School of Public Health).

The lunch break was followed by the second keynote speaker, Prof. Abel B. Veiga Copo, Professor of Commercial Law, Comillas Pontifical University -Universidad Pontificia Comillas- of Madrid. The topic was "Euthanasia, right to die, suicide, palliative care, homicide and its assurance".

The scientific communications selected in the context of the call for papers were presented after the second keynote speaker. The first communicants were Elise Nicoleta Valcu (Romania) and Bogdan Radu (Romania), with the topic "Legislative approaches regarding the protection of consumers involved in legal relations of the provision of cross-border medical services. Improving access to health services, Desideratum for the 3rd SDG". The second speakers were Anthony Novaes da Silva (Brazil) and Carlos Acosta Olivo (Peru), with an intervention entitled "SDG3, Legal Design and New Technologies in life and Health Insurance".

The third keynote speech was delivered by Prof. Maria Luísa Muñoz Paredes, acting as AIDA Europe Representative. The topic of this speech was "Insurance during the Covid-19 pandemic: the European experience".

The second roundtable, moderated by Prof. Maria Elisabete Ramos, was aimed at discussing the market's point of view. Therefore, various representatives of the Portuguese insurance sector presented their policy recommendations around the main topic of the conference. In particular, the table was composed by Maria João Sales Luís (CEO of Multicare, Fidelidade Group), Carlos Suarez (Member of the Board of Victoria-Seguros), and Ana Mota (MDS).

The last keynote speaker of the first day was Prof. Christina S. Ho, from Rutgers University, from the United States, whose speech was centered on the topic "Reinsurance as a human right".

The second day workshop was devoted to the research performed by Ph.D. and Master students. This session was hosted to provide young scholars a safe space to share their research with consolidated researchers. The session started with a brief introduction and discussion of the previous session moderated by Prof. Bolivar Oñoro. Then two Ph.D. students presented their research. First, Willbemis Jerez Rivero was in charge of the topic "People with Disabilities and Access to Private Health Insurance: Recent Developments in Spain". Second, Vítor Boaventura Xavier with the topic "Protecting biodiversity, protecting health: the role of insurance in protecting life on land". Two presentations carried out by Master students closed the Conference under the heading "The adoption of measures to combat exclusion in health care provision by the insurance industry". Ana Sofia Pereira presented the topic "Combatting exclusion on the ground of old age". Rita Calado and Ana Carolina Silva presented a work entitled "Combatting Exclusion on the ground of mental health". These students had been selected from among those attending the course on EU Insurance Law, which is also part of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era. The attendants of the e.course on Insurance and SDG were also allowed to participate.

5. Conference photographs provided by NOVA School of Law. Credits: Raquel Wise

Figure 1 Margarida Corrêa de Aguiar, President of the Portuguese Insurance and Pension Funds Supervisory Authority (ASF)

Figure 2 Prof. Cláudio Soares, NOVA University Pro-Rector and Coordinator of the NOVA Health Platform

Figure 3 Prof. Abel Veiga Copo, Univ. Comillas, Madrid

Figure 5 Carlos Suarez, Victoria Seguros

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Figure 10 Prof. Christina S. Ho, Rutgers Univ.

Figure 11 Ana Mota, MDS, Maria João Sales Luís, Multicare, Prof. Maria Elisabete Ramos, Univ. Coimbra

6. ECOseguros as the Conference's Media Partner

These conference proceedings gather the original contributions of the professionals invited to the event. Therefore, the views here represented are their own, nor the Scientific Committee, nor the editors of this book.

Media partner ECOseguros covered the event by writing a news piece before the conference and another one after the conference. These pieces can be found in the following links:

https://eco.sapo.pt/2023/07/03/nova-impulsiona-debate-sobre-o-futuro-do-direito-dos-seguros/

https://eco.sapo.pt/2023/07/26/especialistas-alertam-para-importancia-dos-seguros-de-saude-em-portugal/

Academia

NOVA impulsiona debate sobre o futuro do Direito dos Seguros

ECO Seguros
3 Julho 2023

A NOVA School of Law e a AIDA Portugal unem-se para lançar a I Conferência Internacional sobre 'Direito dos Seguros na União Europeia: Desafios na Era dos ODS'. O evento reúne especialistas do setor.

Academia

Especialistas alertam para importância dos Seguros de Saúde em Portugal

ECO Seguros
26 Julho 2023

Conferência internacional aponta urgência em fortalecer seguros de saúde em Portugal para assegurar acesso a melhores cuidados médicos. Especialistas reuniram-se para discutir desafios e soluções.

Written Interventions: Some Policy Recommendations

I. Introductory Speech

Margarida Corrêa de Aguiar
President of the Portuguese Insurance
and Pension Funds Supervisory Authority
ASF

I would like to emphasize the importance that the Insurance and Pension Funds Supervisory Authority attaches to the role of Academia in researching insurance and pension fund issues. This year the international conference of the Jean Monnet Module is dedicated to SDG 3: good health and well-being. For this reason, health insurance will have a particular focus in my intervention.

The United Nations resolution ─ "Transforming our world: 2030 Agenda for Sustainable Development" ─ consisting of the 17 Sustainable Development Goals (SDGs) and their targets, represents an action plan to eradicate poverty and hunger, fight inequalities, build just and inclusive societies, protect human rights, the planet and its natural resources. The 2030 Agenda calls for all and sets goals that must be considered in an integrated and indivisible manner, taking into account the various dimensions of sustainable development. Indeed, with the Millennium Development Goals now over, the 17 SDGs are the benchmark for assessing the progress we want to see in our societies and the world we are bequeathing to future generations. We are all called to contribute to a more inclusive, just, and sustainable society.

SDG 3 states that access to quality health and well-being should be ensured for all at all ages. To this end, targets are set to realize the ambition of this SDG, in particular, to reduce the global maternal mortality ratio, end preventable deaths of newborns and children under 5, and strengthen the prevention and treatment of substance abuse. Additionally, SDG 3 sets the goal of universal health coverage, access to quality essential

health services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

Insurance could not be left out of the demanding steps that need to be taken to achieve the SDGs. Admittedly, insurance is only explicitly mentioned in SDG 8, which concerns promoting inclusive and sustainable economic growth, full and productive employment, and decent work for all. However, insurance is a reality in the most diverse activities that contribute to responding to the urgent call of the Sustainable Development Goals.

Society in general, economic agents, and policymakers expect the insurance sector to play a growing and effective role in ensuring the protection and compensation of losses resulting from increasingly diverse and severe risks. By taking out insurance, both individuals and legal entities can transfer a multitude of risks to insurers, who act as specialized agents in managing and mitigating them. The insurance sector thus guarantees the various economic agents mechanisms to protect their assets, to repair or compensate for losses arising from the randomness of human and business life, and also acts to attract and manage savings in the medium and long term. Still, the importance of insurance in society is not limited to the wide range of products it offers.

The insurance sector plays an important role in encouraging good practices and behaviors and in promoting financial literacy, contributing to a more aware and responsible society. The insurance industry also acts as a leading institutional investor, managing a very significant volume of financial assets. All these characteristics of the insurance sector make it an indispensable partner in supporting the fulfillment of the Sustainable Development Goals.

As the 2030 Agenda states, to promote physical and mental health and well-being, universal health coverage and access to care must be guaranteed, with no one left behind. The insurance sector has all the conditions to affirm itself as an inclusive and sustainable sector that contributes to these objectives, through adequate and accessible products,

always bearing in mind that the insurance activity is based on the use of techniques for assessing, selecting, and accepting risks, ensuring that this contribution is also sustainable.

Insurance, and in particular health insurance, has a direct influence on health and access to quality health services. Indeed, health insurance contributes to the removal of financial barriers to health care through risk pooling techniques, allowing access to a variety of health service providers. In Portugal, health insurance is a complementary pillar of the National Health Service. Health insurance has experienced significant vitality in our country in recent years. In a decade, gross direct written premiums have grown from €523 million in 2012 to €1,156 million in 2022, corresponding to a growth of 120%. If we narrow down the observation period from 2019 to 2022, health insurance production increased by 34%, far above the national GDP growth recorded in the same timeframe.

The digitalization of health insurance services, which has accelerated sharply with the COVID-19 pandemic, has contributed to strengthening access to quality healthcare. In this framework, technological innovations such as telemedicine and the various mechanisms that incentivize health insurance beneficiaries to adopt habits are noteworthy healthy, the results of which are reflected in the price and conditions of access to these insurances.

Pricing policies favor changes in customer behavior, which in the case of health insurance equates to greater prevention, often based on specific apps or check-ups offered by the insurers themselves, who are also interested in promoting healthy habits. As a result, there is a potential positive impact on accident rates.

On the other hand, a holistic analysis of the contribution of insurance to the SDGs leads us to conclude that the impact on SDG 3 reflexively influences the pursuit of other Sustainable Development Goals.

Health insurance prevents the negative financial consequences of health costs for families. As such, by contributing to SDG 3, health insurance can support poverty eradication and hunger eradication, enshrined as the first and second sustainable development goals respectively. Also, the demographic evolution of the aging population and increasing longevity pose new challenges for the design and marketing of health insurance. The increase in average life expectancy requires integrated responses to the pathologies that arise with longevity, not only in the field of diagnosis and treatment but also in the field of prevention. Indeed, we can only consider that we are moving towards the goals set by the Sustainable Development Goals if we can respond to the various needs in a specialized, careful, competent, and efficient way.

The references I have just made, which are admittedly very brief, show that insurance should not be seen as an accessory instrument in the pursuit of the SDGs. A word is due to the key role of supervisors in building an insurance sector that contributes to the Sustainable Development Goals.

I emphasize that the mission of the Insurance and Pension Funds Supervisory Authority is "to ensure the smooth functioning of the insurance and pension funds market by promoting the financial stability and soundness of the entities under its supervision, as well as by ensuring that they maintain high standards of conduct".

In particular, it is responsible for regulating and supervising insurance activity, as well as promoting the development of technical knowledge and its dissemination and the enhancement of financial literacy in insurance. A robust insurance market, where operators act diligently, fairly, and transparently in their dealings with policyholders, insured persons, and beneficiaries, contributes to the provision of insurance that adequately responds to risks that can adversely affect households and businesses.

The information to be provided to consumers on health insurance ─ which should apply to all insurance ─ should be accessible, understandable, simple, and transparent.

It is in this context that ASF has categorized as a strategic priority in its latest activity plans the investment in a set of initiatives aimed at improving the quality of health insurance regulation and supervision. This concern is linked to the growth of health insurance in our country, which covered 3.5 million beneficiaries at the end of 2022. Among these initiatives, I mention the construction of a dedicated Health Insurance Portal and a permanent Health Insurance Observatory. The Health Insurance Portal will include product information, FAQs, tips and alerts, financial literacy content, and applicable legislation and regulations, among other content. The Health Insurance Observatory will provide up-to-date indicators on the size, structure, valuation, and performance of this business segment, as well as other important information, presented in a systematic, detailed, and appealing way, aimed at consumers.

The aim is to improve access conditions and promote information mechanisms that empower consumers in the choices and decisions they make and in the exercise of the rights and obligations arising from the subscription to health insurance. ASF will continue to strengthen the day-to-day supervision of health insurance activities, based on a close link between supervisor and supervisee, with permanent verification of the entire product life cycle, the quality of the relationship with customers, and the adequate performance of the agreed medical networks.

I conclude my speech by wishing that the first International Conference of the Jean Monnet Module on Insurance Law of the European Union will be a forum that promotes fruitful discussion on the Sustainable Development Goals and raises awareness of the importance of all of us contributing to them. It is particularly enriching to convene experts and the most diverse stakeholders to think together — constructively, deeply, and realistically — about the progress and difficulties in pursuing the SDGs. It is also an opportunity for us to recognize the effort and work put in by public and private entities on the hard road toward sustainable development.

I believe that we all count on meeting the challenges of building a world in the light of the Sustainable Development Goals and, as such, we all must be guided by this "GPS" in the activities we pursue and the decisions we make. The insurance sector has been and will continue to be an active player, has enormous potential to respond to this challenge, and will not fail to use it responsibly.

II. The role of insurance in the healthcare sector: some data

Pedro Pita Barros
BPI | La Caixa Foundation
Professor of Health Economics
Nova School of Business and Economics

The first point in the discussion of the role of health insurance in Portugal is to define its role: health insurance exists to protect against the adverse effects of financial costs associated with the use of health care.

Health insurance, in this sense, is provided by different entities. The public sector provides health insurance through the National Health Service, funded by taxes. There is occupation-based health insurance (called health subsystems), by both private and public entities. This health insurance is funded by a mix of contributions from the beneficiaries and the companies/ employers. It covers the workers of the base companies or entities (including the Government), and their families. There is also private commercial health insurance, either via individual policies or group policies. These different origins of health insurance have evolved over the past 20 years in significant ways. The focus here is on private health insurance, with a look at facts and myths about it in Portugal.

I start by pointing out five facts.[1]

Fact 1: Since 2000 the number of policies in the private health insurance market and its weight in the funding of the health care expenditures more than doubled.

Fact 2: more than 40% of the Portuguese population has private health insurance of some sort.

[1] A full description of data supporting these facts is provided in Pedro P. Barros and Eduardo Costa, 2022, Seguros de saúde privados no sistema de saúde português: mitos e factos, Observatório da Despesa em Saúde 2, BPI | la Caixa Foundation Chair in Health Economics.

Fact 3: the funding associated with private health insurance was less than 4% (four percent) of total health expenditure in 2020.

Fact 4: Private health insurance growth was not associated with a decrease in the out-of-pocket payments of families.

Fact 5: The growth of private health insurance had as a major counterpart the decrease in private health subsystems.

To discuss the implications and the role of private health insurance, it is useful to consider three different types of coverage that private health insurance provides in its relation to public health insurance (as provided by the National Health Service).

The first type is duplication of coverage. The private health insurance contracts offer the same coverage provided by the National Health Service (NHS).

For this particular category of private health insurance, its expansion should be linked to a reduction in the NHS's involvement. This could stem from gaps in healthcare provision within the NHS, diminishing the efficacy of health insurance coverage. As a result, individuals might seek private health insurance to address these gaps. Alternatively, private health insurance contracts could provide more appealing conditions compared to the NHS, particularly in terms of accessing care providers. These effects might even coexist simultaneously.

The second type of health insurance is supplementary private health insurance, that is, private health insurance coverage that covers the part of the cost to the patient that is not covered by the NHS. In this case, the evolution of funding sources should display stable NHS funding coupled with decreasing out-of-pocket expenditures.

The third type is complementary private health insurance, in which private health insurance covers services that are not available (coverage or provision) by the NHS. An

increase in the role of this type of insurance should also be associated with a decrease in out-of-pocket expenditures by households.

Analysis of the evolution of broad categories of funding sources of health care expenditure in Portugal, according to the National Health Accounts published by Statistics Portugal, shows that out-of-pocket payments from households remain at a very high level. There was no visible reduction in its proportion of total health expenditure in the last ten years. This means that companies that offer private health insurance have not taken advantage of the lack of financial coverage of many health care expenditures to expand their business. It is unclear whether this happens because there is no business opportunity for insurance to cover those out-of-pocket expenditures. After all, there is not enough effort in the identification of those opportunities because other lines of development of private health insurance activity were found more attractive by insurance companies.

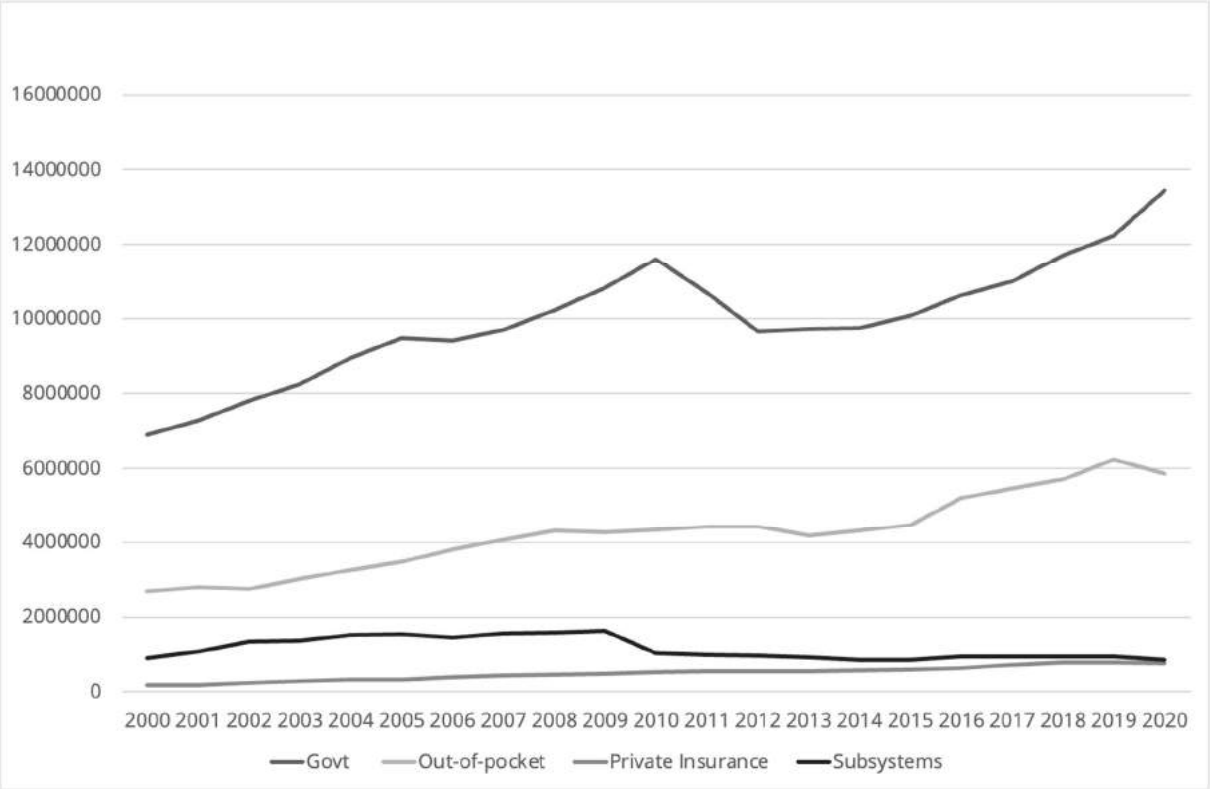
Table 1: Sources of funds in the Portuguese health system

Sources of funds	2000	2005	2010	2015	2020
NHS	58,62%	57,53%	59,47%	57,27%	56,36%
Public Health Subsystems	6,27%	7,89%	4,14%	3,74%	3,06%
Other public sources	4,73%	5,10%	5,17%	3,93%	4,97%

Public SS	0,85%	0,76%	0,99%	1,24%	2,41%
Private insurance	1,49%	2,22%	2,99%	3,71%	3,58%
Private Health Subsystems	2,15%	2,37%	1,73%	1,49%	0,94%
Households	24,98%	23,31%	24,56%	27,73%	27,80%
Other private sources	0,91%	0,83%	0,95%	0,91%	0,88%

Source: own construction, using National Health Accounts, Statistics Portugal

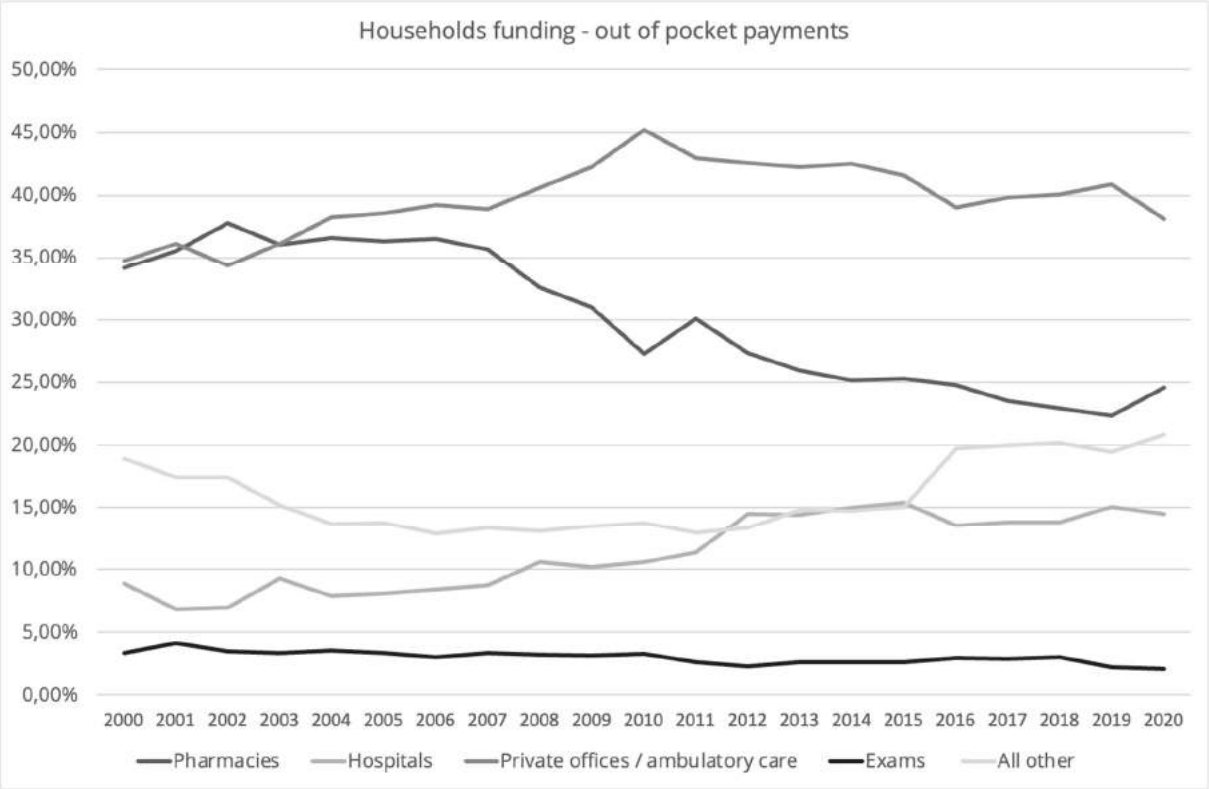
Figure 1: Evolution of broad funding sources



Source: own construction, using National Health Accounts, Statistics Portugal

It is clear from the aggregate data of the National Health Accounts that the expansion of complementary (to the NHS) private health insurance did not take place. This is a sort of puzzle as a high proportion of households' out-of-pocket expenditure is on private medical offices and ambulatory care (Figure 2). The puzzle lies in why unexpected health expenditure by households on private medical offices is not the object of insurance by individuals based on adequate private health insurance contracts offered by commercial companies.

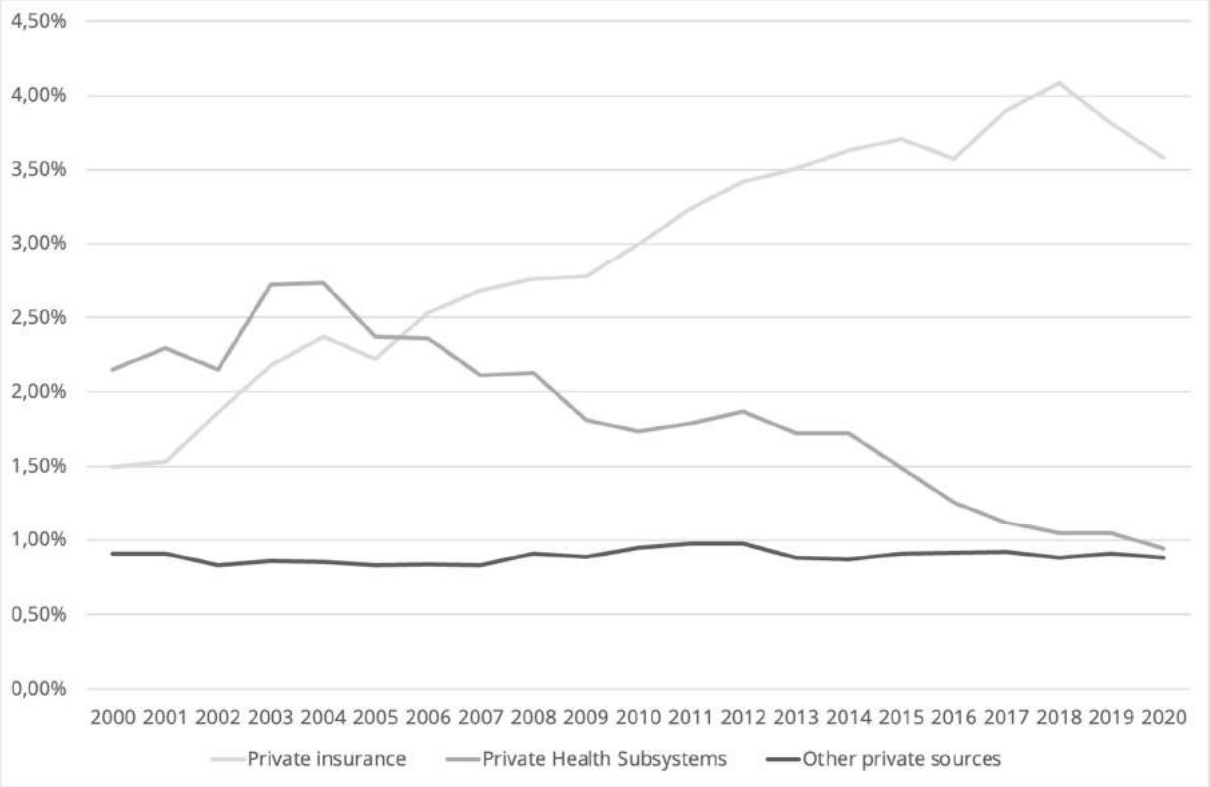
Figure 2: Evolution of households' spending



Source: own construction, using National Health Accounts, Statistics Portugal

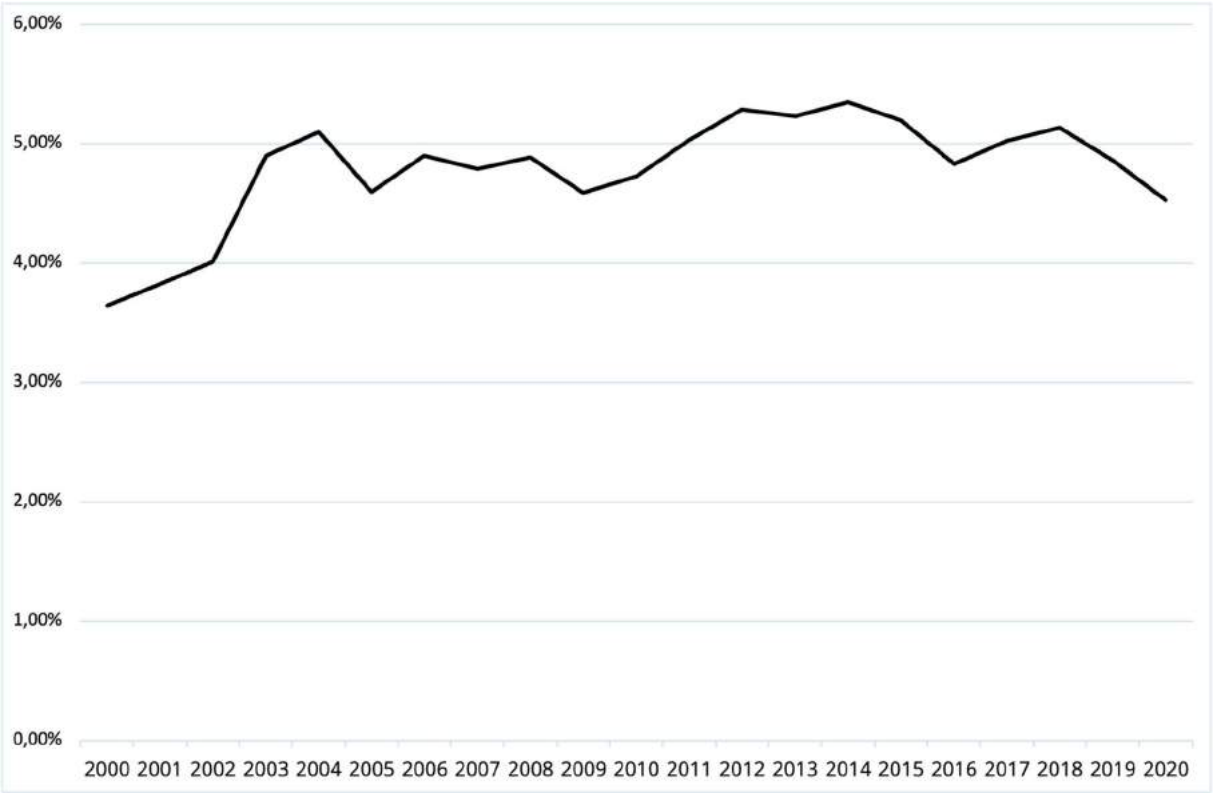
This raises the question of where the growth in private health insurance comes from. A possible explanation lies in the decrease in the private health subsystems (occupation-based health insurance provided by private companies). The growth of the role of commercial private health insurance is matched to a considerable extent by the decrease in the role of private health subsystems. When adding both sources of funding for health expenditures (Figure 2), the aggregate of private health insurance and private health subsystems shows only a small growth over the past two decades. Thus, the growth of private health insurance seems to be mostly the result of replacing private health insurance subsystems.

Figure 2: Private funding sources (excluding households) in the Portuguese health system



Source: own construction, using National Health Accounts, Statistics Portugal

Figure 3: Private health subsystems and private health insurance



Source: own construction, using National Health Accounts, Statistics Portugal

There are several possible reasons for this evolution. The first one is that it is probably simpler to manage this substitution within the private insurance market than to define and get to the market coverages of insurance that would reduce considerably the out-of-pocket payments. A second reason is the existence of technical challenges in some types of health insurance coverage: for catastrophic events, there is no replacement for the NHS as a last resort for protection, and for chronic conditions, the basic element of risk diversification for insurance may fail, as people with a certain condition today have a probability 1 of having that condition in the future and needing health care (they will give origin to certain health expenditures in the future (say next year)). In these cases, the actuarially fair

"price" for the insurance contract would be equal to certain expenditures, leading to no economic space for a contract. For chronic conditions. It is possible to consider other types of risk diversification. Instead of diversifying risk in the same year across different people, one may think about some sort of intertemporal insurance, with risk diversification across years for the same individual (having some sort of medical savings account to be used after becoming a patient with chronic conditions). Such type of health insurance requires payments over time that are difficult to compute and require long-term contractual relationships and payments associated with the transfer of contracts across health insurance companies. It is not a practical solution. Finally, the market for the coverage of the health care services that make the bulk of the out-of-pocket payments may be affected by the strategic behavior of companies namely offer contracts that self-select good risks (cherry-picking on other health insurance companies).

From the observation of the data on health expenditures sources of funding over the last 20 years in Portugal, we can extract several findings, some of which are aligned with general perceptions about the market while others debunk "myths" about the role of health insurance in Portugal.

First, private health insurance had a strong growth over the past two decades: true, according to the Global. numbers made available publicly by Statistics Portugal. second, private health insurance is destroying the NHS: false, no evidence increasing private health insurance has led to lower NHS funding. third, private health Insurance takes a "culture" strategy on the NHS, by offering duplicated coverages (from a health system perspective) to take advantage of NHS deffie hats. This may happen in some cases. It is not (yet) sufficiently large to show up in the aggregate statistics on the sources of funding for health care expenditures. Fourth, private health insurance explores the gaps in coverage of the arts: false, as we do not see a reduction in the out-of-pocket expenditures, a would-be implication of private health insurance growing by offering new coverage plans. Fifth, private health insurance increased its role in the Portuguese system by taking

up the space previously occupied by health subsystems i true, this was the main effect associated with the growth of private health insurance.

II. Euthanasia, right to die, suicide, palliative care, homicide and its assurance

Abel B. Veiga Copo
Professor of Commercial Law
Comillas Pontifical University of Madrid

SUMMARY: 1. Introduction. 2.- Is there a right to die and a right to be insured? The incidence of suicide in the insurance contract. 4. 4.- Suicide. 4.1.- Beyond voluntariness. 4.2.- The natural insurability of suicide. 5. Suicide, somnambulism, dementia, hypnotism, drugs. 6. 6.- Nullity or release of the insurer. The redemption of the premium. 7.- Homicide in life insurance. 8.- A false duality, homicide v. euthanasia.

Introduction

Since euthanasia was approved in Spain in 2021, questions about the insurability or otherwise the right to die, as well as the line between palliative care and life insurance, have once again burst into the insurance debate and study. Without questioning at this point or going into the perimetry of this right, its essence, consistency, and existence, or the good to be protected, the truth is that this was not a field where the doctrine openly entered. This does not mean that there were no studies or reflections on the same, except perhaps in the field of suicide, probably one of the most classic, and undoubtedly attractive for study from the perspective of life insurance[2] . Does life insurance cover the

[2] One of the classic works, but at the same time the first in this field, at least monographically, we owe to VIVANTE himself, *Il suicidio nelle assicurazioni sulla vita*, Bologna, 1890. The first lines of this small essay focus directly on the appreciation of the social context of suicide after a famous quote from Beccaria, Dei delitti e delle pene. Thus, Vivante states on p. 3: "La triste ombra del suicidio accompagna il progresso luminoso della civiltà divenendo sempre più oscura, come se questa volgesse al tramonto. The statistic with its inesorabili confrontations of the present with the past warns us of its continuous increase: this is so constant that it could with many probabilities follow the line of its development in the future. Nei centri più operosi e più colti, fra gli uomini che combattono colvello le battaglie della vita, là dove sono più intense le crisi economiche e finanziarie, nei mesi più caldi dell'anno, il suicidio percuote le schiere dei combattenti". And on p. 4 he links it to a religious society, thus, he states: "Il triste spettacolo di cittadini laboriosi ed onesti che si uccidono per non sopravvivere al disnonore, all'abbandono, all'indigenza che altri

death caused by the insured? How is this coverage compatible with the axiom of the malice or bad faith of the insured person?[3] One of the most controversial questions in the field of personal insurance in the past was the relationship between suicide and life insurance[4] . Faced with an initial refusal, the field of insurance gradually permeated to the point of allowing coverage, conditional in some cases on the passing of a short period, of the risk of suicide[5]. How does this coverage fit within a framework of incontestability of the policies or clauses?[6] An area to which other areas, such as criminal law, were no strangers, and in which it was subsequently decriminalised. Reasons of public order and morality initially prevailed in favour of the refusal of coverage and later focused on

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soporta cínicamente; per agevolare alla familia un soccorso cui vivendo ponevano ostacolo; per troncare ai propri cari il penoso dovere di assiterli contro gli assalti di una malattia incurabile, ci rende più che mai insofferenti di quelle conclusioni scientifiche. The frequency of suicide disturbs society in its most intimate and operative forces: in its religious and human faith, in the cult of work and family".

[3] One of the most recent judgments dealing with suicide and intentional act, we find in the judgment of the Court of Cassation, 2 Civ. of 20 May 2020, no. 19-11538. Certainly in France after 2013, the Court of Cassation, 2.ª, "is reliant on the dualist conception, in which the intentional tort is characterised by the will of its perpetrator to "create the damage as it arises", tandis que la faute dolosive consiste en une faute "délivérée" dont l'auteur a conscience qu'elle a "pour effet de rendre ineluctable la réalisation du dommage et de faire disparaître l'aléa attaché à la couverture du risque"". In this line also the Cassation judgement of the 2nd Civil Chamber of 25 October 2018, no. 16-23103.

[4] For TAYLOR, *The law of insurance*, New York, 1983, p. 25 suicide was "the act of self-destruction may be the result, obviously, of one or more non-economic factors. In some instances, however, the act of suicide by an insured has been triggered by the thought that-substantial insurance monies would come to one's dependents".

[5] With clear medical lexicology, the Supreme Court of Colombia in its ruling of 19 December 2018 [SC5679/2018], states:

"Suicide, in spite of being a volitional act by definition, is an insurable risk because the victim commits it, in general, in a pathological state of neurobiological affectation which prevents him from making a free decision, even when he is conscious of his conduct and wants its result; since self-annihilation is produced by the impossibility of responding assertively to the conditioning factors of the environment, which are presented to the individual as an irresistible force. Hence, this risk is covered by the policy from the beginning of its validity, without it being admissible to impose abusive clauses on the user of a life insurance contract which aim to presume bad faith or fraudulent intent. In order to exclude the payment of the claim due to facts that do not depend on the exclusive will or mere power of the insurance user, which is precisely the object of this legal business".

[6] In this sense, MORRIS, "A right to die, a right to insurance payouts? The implications of physician-Assisted suicide on life insurance benefits", Montona Law Review, 2020, vol. 81, no. 2, pp. 212 ff, p. 225 "Like inconstestability clauses, some insurers include suicide clauses within their life insurance policies. Suicide clauses generally exclude coverage for death by suicide and insurers generally return the monthly payments made toward the policy's premium, at least for suicides that occur within the contestable period. Suicide clauses act as a deterrent for insureds who purchase life insurance with the intent to harm themselves".

intrinsically technical reasons[7]. Is it normal or abnormal, is it moral or amoral to take one's own life?[8] This was an old debate that circumscribed the entire 19th century from a sociological, legal, and religious point of view[9]. A controversy that went beyond the strictly insurance-related to take on strong religious, ethical, moral and sociological connotations, as well as criminal and strictly medical ones[10]. When does a death also have

[7] Against public policy criteria, the position of HALPERIN, *Contrato de seguro*, 2nd ed., Buenos Aires, 1966, p. 521 stands out. The Argentinean treatise writer stated that it is necessary that the suicide be voluntary, committed in a state of normal, free consciousness. In no way should it be understood that it is committed in order to pay the benefit or that it is already contracted with the idea of committing suicide. On this key point, LORDI, "Il suicidio nell'assicurazioni", Riv. Dir. Comm, 1934, vol. 2, p. 82. A century earlier MORPURGO, "Raccolta di osservazioni sulle assicurazioni marittime e sopra le sicurtà contro i danni ignei, fluviali ed aerei e quelle sulla vita dell'uomo e per i vitalizi", Trieste 1834, III, pp. 27-28 stated: "In any insurance contract there must be a risk, the nature of which is fortuitous and does not depend in particular on the will of the person interested in increasing it, or resolving it in damage. In the insurance of human life, the insurer assumes the risk of damage that can lead to death. But this must be natural, and he never assumes the risk that depends on the will of the insured, and on some of his criminal action, because that would be contrary to his moral purpose, and would therefore lead to the creation of disorder and the commission of the crime. Therefore, when an individual assassinates his own life, the Assicurators will not be held to any indemnity, if he loses it by suicide, in grief or by the hand of justice in consequence of committed crimes".

[8] DURKHEIM, *El suicidio*, Madrid, 2004, p. 495 "we are accustomed to consider abnormal everything that is amoral. If, as we have shown, suicide offends the moral conscience, it seems impossible or impossible to see in it a phenomenon of social pathology,.... even the eminently immoral form, namely crime, should not necessarily be classified among the morbid manifestations".

[9]On this point, FORTUNATI, "La pietosa ingiustizia dei magistrati". "Il dibattito sul suicidio dell'assicurato tra Ottocento e Novecento", Historia et ius, 2016, n.º 10, paper 30, pp. 1 et seq., p. 5 states in reference to the position in the nineteenth century: "in the absence of a precise regulatory framework, insurers ended up establishing an autonomous way, through their own policies, limiting and circumscribing the hypotheses of compensation. Secondly, this sector was also obviously affected not only by the penal sanctions, but also moral sanctions, which for a long time had accompanied suicide and profoundly marked the discipline of the matter". VIVANTE, Il suicidio, cit. stated, faced with the possibility of insurance fraud through suicide, p. 16 "La difesa dell'ordine pubblico in questa materia ha, secondo il mio avviso, questo modesto ufficio e nulla di più: impedire che un cittadino decido di suicidarsi ricorra all'asicurazione per speculare colla propia morte in frode della Compagnia". The Italian author was in favour of temporary clauses of between three and five years after the conclusion of the contract. And he added: "Posto questo impedimento alla frode e salvata così la sacra fede del contrato, devono cosiderarsi benemerite le Compagnie che, soppressa ogni cagione di questionare sovra una tomba, accolgono nelle loro polizze quella clausola".

[10]However, it was not only the insurance sector that was reluctant to deal with suicide. RODRÍGUEZ SANTOS, "La protección social del suicidio del trabajador en el sistema de la Seguridad Social", Aranzadi Social, 2010, no. 13 [electronic resource] states: "One of the cases that has raised doubts about its classification as a contingency protected by Social Security has been the singular case of "suicide". Initially understood as an act that was totally excluded from protection, there was a subsequent evolution in the jurisprudential line that marked a before and after in its delimitation as a protected contingency, as an accident at work. Until the end of the 1970s, the Supreme Court denied the status of an accident at work to suicide regardless of the factors and circumstances involved in the worker's act, considering it to be a

a clear suicidal etiology? What about assisted suicide and euthanasia?[11]. Would it be covered by the insurance policy? What about certain cases of sedation in terminal or degenerative illnesses in which the patient, the insured person, is fully aware of the decision he/she is taking? What about a living will in which the insured makes clear his/her will regarding his/her personal situation and the medical treatments?

Is there a right to die and a right to be insured?

The debate today goes beyond the mere fact of suicide and self-harm per se, to a more ethical and legal level, apparently contradictory and full of controversy. For example, can we speak of an individual right of a patient to die? Or, conversely, is there or is there a legal absence of such a right or alleged right of a patient to die?

Suicide and euthanasia are two concepts today, as well as dramatic realities, in which the ethical and the legal, the regulatory and the medical problem are closely intertwined to provide a clear and effective response, especially in the case of suicide, traditionally hidden from society and the media, and where the shortage of specialized health personnel is one of the enormous difficulties in preventing it. Is the right to die ultimately a fundamental right?[12]. Has any supreme or constitutional court ever declared it as such?[13]. Not so much so, at least it does not fit in with the above, the question of palliative treatment and the provision of such treatment through insurance. Most policies cover

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voluntary act that breaks the causal relationship". See the recent multidisciplinary study by BLANDÓN CUESTA, *et. al., El suicidio: cuatro perspectivas*, Medellín, 2019, which analyses the interdependence of suicide from four perspectives: neuropsychological, theological, epidemiological and sociological.

[11]On this relationship see CAVINA, *Andarsene al momento giusto. Culture dell'eutanasia nella storia europea*, Bologna 2015, pp. 36 ff.

[12] See the recent contribution by CÁMARA VILLAR, "La tríada "bien constitucional vida humana/derecho a la vida/inexistencia de un derecho a la propia muerte" (acerca de la constitucionalidad de la regulación de la eutanasia en España en perspectiva comparada)", *La eutanasia a debate. Primeras reflexiones sobre la Ley Orgánica de regulación de la eutanasia*, [TOMÁS-VALIENTE LANUZA (Ed.)], Madrid, 2021, pp. 25 and following, where the author analyses and goes beyond the paradigm of "dignified death".

[13] On this point MORRIS, "A right to die", cit., p. 214, notes that the American Supreme Court has not done so, but that the legislations of nine American states have legislated on this path, recognising the right to die, or "death with dignity" laws.

palliative care or treatment, but the scope of such care or treatment is another matter. Policies differentiate and specify between palliative care and palliative care at the end of life or for the terminally ill or "hospice".

About suicide, we must bring into the debate the contours of assisted suicide and whether it is covered by an insurance contract. It is in this doctrinal discussion that we must anchor whether there is indeed a right to die or to put an end to human life[14]. A right that can swing, at least theoretically, between being a fundamental right or a protected right, the reality is that dogmatically there are three different types of assisted death[15]: on the one hand, active euthanasia, on the other, passive euthanasia, and finally PAS -Physician-assisted suicide- or physician-assisted death[16].

Active euthanasia implies that the physician participates, and acts, for example, through his or her participation in a positive action of "injecting a lethal dose of opioids into the patient, to cause death"[17]. Passive euthanasia, by contrast, refers to the point at which a patient dies due to "a physician's inaction or omission, such as withholding hydration and nutrients or refusing to initiate life-saving therapies". In contrast, assisted suicide does not require physician action or inaction; rather, "the physician assists the suicide by

[14] Classic treatise by MEISEL/CERMINARA/POPE, *The right to die. The law of end-of-life decisionmaking*, 3rd ed., New York, 2022-1 Supplement.
[15] MORRIS, cit., p. 219 reminds us that in 1997, the United States Supreme Court heard two cases involving the right to die -Vacco v. Quill and Washington v. Glucksberg. In both decisions, the Court held that a person does not have a fundamental right to die and that the State has a legitimate interest in preserving the lives of citizens. However, in both cases the Court acknowledged the inadequacy of current palliative care, hinting that there may be a constitutional right to palliative care, thus opening the door to the possibility of cases involving this issue in the future. And yet ten years later he argues: "Nearly ten years later, in 2006, the Court once again heard a case regarding assisted death after Oregon's Death with Dignity Act was in effect for almost a decade. In Gonzales v. Oregon, the Court held that, under the clear language of the federal Controlled Substance Act, the Attorney General cannot prohibit physicians from prescribing drugs to facilitate PAS. Gonzales was the last time the Court has heard argument regarding the right to die".
[16] In depth see CHAMBERLAIN, "Looking for a Good Death", 17 Elder L.J., 2019, vol. 17, pp. 61 et seq.
[17] Thus, see McMURRY, "Comment. An unconstitutional death: The Oregon Death with Dignity Act's Prohibition Against Self-Administered Lethal Injection", Dayton L. Rev., 2007, vol. 32, pp. 441 ff, p. 449.

offering medical expertise, but does not actively or passively participate in the actual event of death"[18].

And the fact is that, almost up to the present, the pattern has been clear, namely the invisibility of suicide in our societies and culture through absolute silencing and rejection[19]. An invisibility even in law, which is manifested by a certain ambiguity concerning insurance and the dictate of Article 93 LCS. As sociology has rightly pointed out, "suicide is called "any case of death resulting directly or indirectly from a positive or negative act, carried out by the victim himself who knew that it was going to produce that result"[20].

What happens in those cases, for example, in which the potential insured or policyholder knows that he or she is suffering from an incurable and irreversible illness and takes out a life insurance policy knowing that he or she wants to put an end to his or her life? A question which, a priori, is not like the hypothesis in which the knowledge of this terminal illness is already present in an insurance policy, but where the insured person will still claim euthanasia or assisted death. Or, what happens in a life insurance policy when the beneficiary participates in some way in the euthanasia?[21]

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[18] For example, the physician may provide the means for death, such as writing a prescription for the patient, while the patient takes the active step of ingesting the prescribed drug, thus causing death.

[19]The words of VIVANTE, *Il suicidio nelle assicurazioni sulla vita*, Bologna, 1890, p. 12, still take on a certain prominence when he affirmed: "I agree with the massima tradizionale che insegna a considerare il suicidio como malefizio sociale. Anche io sono d'avviso che ognuno abbia il dovere di vivere, perché la vita di tutti è indispensaiblie al normale e progressivo svolgimento delle forze sociali". In analysing the burden of proof of suicide, HALPERIN, *Insurance Contract*, cit. p. 525, Drástico stated that "suicide - in the vast majority of cases - is not an act committed by normal people. Suicide is a phenomenon of abnormality".

[20]For the French author, what is common to all possible forms of supreme renunciation is that the act by which they are carried out is with knowledge of the cause; that the victim, at the moment of acting, knows the consequences of his conduct, whatever the reasons that have pushed him to this conduct may have been. All deaths with this characteristic feature are clearly distinguishable from those in which the patient subject is either not the agent of his own death, or is only the agent of his own death unconsciously.

[21] On the figure of the participant, see, in extenso, PEÑARANDA RAMOS, "Participación en suicidio, eutanasia, autonomía personal y responsabilidad de terceros", *La eutanasia a debate. Primeras reflexiones sobre la Ley Orgánica de regulación de la eutanasia*, [TOMÁS-VALIENTE LANUZA (Ed.)], Madrid,

Now, is the person who ends his or her life always and, in any case, aware of the result of the action, whether positive or negative, of taking his or her own life and is it a fortuitous event when a suicide occurs? Could it be argued that a person who commits suicide consciously and voluntarily is in some way committing fraud against the insurer?[22] Why is there a certain condemnation or reproach of amorality or reproach of abnormality when a person commits suicide? And finally, is an insurer obliged to respect the final will and post-mortem consequences of an insured person who takes his or her own life or asks for help or medical assistance to end a life in certain circumstances which, as regulated by the euthanasia regulations, is incurable, terminal and in pain?[23] In other words, would the clauses of the life insurance contract be applicable in the event of such a decision, assisted suicide or euthanasia, whether active or passive? In addition to this, there is also case law in pronouncements such as those of the Colombian Constitutional Court in C-233 of 2021 of the Plenary Chamber in which it extended the right to die with dignity to patients suffering from a serious illness or injury to non-terminally ill patients, provided that they suffer unbearable pain (in the case in question was a person who had demanded the right to euthanasia and who suffered from ALS).

2021, pp. 199 ff, especially from p. 222 ff, in which the author studies the exemption from responsibility for causing the death of another person or active cooperation in their death if the provisions of the LORE are complied with.

[22]MAGGE, *Life insurance*, 3rd ed., Illinois, 1958, p. 425 when relating suicide to incontestability clauses stated that, "to sell life insurance to persons planning to kill themselves and to permit such policies to be paid out would be tantamount to an invitation to suicide", but he also stated: "the financial situation of a family is equally desperate if the death of the principal producer is caused by suicide as if the death is caused by any other reason". The American author concluded: "On the other hand, to sell insurance to persons planning self-destruction and to permit such policies to be paid would be to invite self-destruction. Life underwriters calculate suicides in their mortality experience. The do not, however, expect life insurance to invite suicide".

[23] MORRIS, cit., p. 215, speaks of certain safeguards against the right to die and insurance policies, stating: "These safeguards require that insurers honour an insured's decision to participate in PAS; thus, an insured's participation in PAS cannot affect the applicability of relevant insurance policies. Despite these safeguards, the broad statutory language in PAS legislation allows insurers to attempt to avoid coverage if an insured participates in PAS".

Perhaps one of the key areas to be analyzed is not whether the insurance covers the risk of suicide, of which today there is no doubt of such coverage, peaceful in any case and accepted by all[24]. Not in vain and for this reason no less eloquent is the initial wording of article 93 LCS, "unless otherwise agreed...". The distortion does not come from its coverage, but from the ellipsis that doctrine and jurisprudence have made on this assumption regarding voluntariness, awareness, and consciousness of committing, voluntarily, the action of taking one's own life. It is voluntariness and intentionality that must be reconciled with another axiom at the frontier of insurance law, malice, and good faith. Voluntariness can even include not declaring to the insurer that one is suffering from a terminal and incurable illness or the wish for an assisted death. In addition to coverage that goes beyond the pure conceptual nucleus of suicide to configure new or different assumptions, such as euthanasia and death assisted by a health professional[25]. Whether or not this assisted death preserves the integrity of a health profession, whether it violates and contrasts two key rights, the individual right of the person to decide freely how to die - if we are talking about a right or a mere constitutional interest - with the public interest of protecting human life against suicide, preserving life, the medical

24As LANDINI, "Art. 1927", *Dei singoli contratti*, Commentario del Codice Civile, [VALENTINO (a cura di)], Torino, 2011, pp. 294 and following, p. 295, suicide is an extreme gesture that can hardly suggest a fraudulent attempt by the insured to profit from the compensation; it is the third party, in any case, the beneficiary designated by the insured, who will receive the compensation.

[25] See, among others, the works that extraordinarily condense the positions on assisted death in the USA, such as LEGAULT, "I Don't Want to Die, but I am Dying": Reexamining Physician-Assisted Suicide in a New Age of Substantive Due Process, Ariz. L. Rev., 2019, no. 60, pp. 509 ff; RICHARDS, "Death with Dignity: The Right, Choice, and Power of Death by PhysicianAssisted Suicide", Char. L. Rev., 2017, vol. 11, pp. 471 et seq. However, MORRIS, cit., p. 217 summarises very neatly the positions for and against PAS, stating: "While proponents argue that there is a constitutional liberty interest in choosing to die through PAS, opponents of legalizing PAS argue that the state's interest in protecting life outweighs this personal liberty interest. In their arguments, proponents of PAS typically cite to inadequate palliative care in pain management and the right to choose one's means of death with dignity. Additionally, proponents argue that refusing life-sustaining treatment, which is legal in most states, produces the same end results as PAS-death of the terminally-ill patient. Thus, in their view, there is no substantive basis for distinguishing the legality of death by refusing life-sustaining treatment and PAS. Conversely, opponents of PAS typically cite to the state's interest in preserving life and preventing suicide, maintaining the integrity of the medical profession, and protecting "vulnerable groups."

profession, and the most vulnerable groups[26]. Open and confronting debate from two great opposing poles[27]. And where ethics and morality are added to a legal and juridical background[28].

As we have advanced, one of the keys to these coverages will come from the wording and content of the clauses, from those of incontestability to those specific to suicide, euthanasia, and assisted death. Both in their definition, if there is one, and in their coverage, whether temporarily conditioned or not. A sensu contrario, the clause that excludes the risk of suicide is perfectly valid and neither abusive nor disproportionate,

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[26] Vid., KLEINBERG/MOCHIZUKI, "The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases", HARV. C.R.-C.L. L. REV., 1997, vol. 32, pp. 197 ff, p. 209; ADAMSON, "The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Terminally Ill Patient: An Analysis of Abridgment and Anarchy", Pepp. L. Rev., 1990, vol. 17, pp. 461 et seq. p. 464.

[27] A good reference in DUGDALE/LERNER/CALLAHAN, "Pros and cons of Physician Aids in Dying", 2019, [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6913818/], where the authors play with the term medically assisted and point out in their contrast to euthanasia: "Supplanting the word "physician" with "medical," for example, makes it possible for non-physician clinicians to prescribe the lethal medications. Some advocates of AID prefer not to use the term "suicide;" they contend that AID is a medical practice, distinct from the act of suicide for a depressed or hopeless person. By contrast, opponents maintain that the process of prematurely and deliberately ending one's life is always suicide, regardless of motivation. Some insist that dissociating "physician-assisted suicide" from other types of suicide demeans those who die by suicide for other reasons, as if only medically-assisted suicides are legitimate. People on both sides of the issue worry whether "aid in dying" or "assisted dying" might be confused with palliative, hospice, or other care of dying patients.

In the United States, physician-assisted suicide or aid in dying has always been carefully distinguished from euthanasia. Euthanasia, also called mercy killing, refers to the administration of a lethal medication to an incurably suffering patient. It may be voluntary (the patient requests it) or involuntary".

[28] On this issue, RUBIN, "Assisted suicide, morality, and law: why prohibiting assisted suicide violates the establishment clause", Va. L. Rev., 2010, vol. 63, no. 3, pp. 761 ff, that general prohibitions against assisted suicide violate the establishment clause because they support a particular, religion-based moral position. Many laws overlap with religious prohibitions, of course. The conclusion that laws against assisted suicide are unconstitutional because of their religious origin is based on the specific historical context of these laws within our current culture. Throughout Western civilisation, attitudes about suicide have ranged from positive approval in many Greek and Roman sources, to outright and unalterable opposition by Christian writers, to limited acceptance and approval by contemporary secular thinkers and health professionals. Today, traditional Christian morality and an emerging secular morality centred on the value of self-fulfilment are in conflict within our society, a conflict that probably reflects a slow historical transition from the former to the latter. The intense debate over the morality of assisted suicide is one aspect of this conflict. Blanket bans on assisted suicide support one side of this debate, a side that is allied with the Christian religion. Consequently, these laws violate the establishment clause".

another question is whether it should include involuntary or unconscious suicide or suicide not attributable to the insured due to his mental situation[29]. This sphere undoubtedly does not belong to the limitation of the insured person's rights, given that he does not have the right to this insurance, but to the genuine objective delimitation of the risk and, therefore, alien to the specific requirements of incorporation of the former. It is a different matter if we advocate that all this pathology of clauses should comply with stricter, more concise, and clearer requirements[30].

The impact of suicide on the insurance contract

What is the true intensity of suicide in the assessment of risk in an insurance contract?[31] Is or can suicide in any way be understood as an accident?[32] If the law does not prohibit

29On this point, see STS, 1.ª de 10 de febrero de 1988 (RJ 1988, 936), which admits the exclusion established in the policy and, on the other hand, it is not proven that *"the suicide considered to be the cause of death (...) was due to an unconscious or involuntary cause of the insured himself, that is to say, the consequence of a mental situation which deprives him of all control over his actions and which causes unconsciousness or involuntariness which produces unconsciousness or involuntariness of the insured.) was due to an unconscious or involuntary cause of the insured himself, that is to say, a consequence of a mental situation that deprives him of all control over his actions, resulting in unconsciousness or involuntariness producing a lack of value of the human act imputable to the person carrying it out".*

30SALAS CARCELLER, "Suicidio y seguro de vida", Aranzadi Doctrinal, 2016, n.º 11 [electronic resource], points out how the question arises as to how this exclusion should be reflected in the policy. It could be thought that it is a clause of delimitation of cover insofar as it refers to the establishment of the object of the insurance - in this case, it would be the death of the insured that is not caused voluntarily by himself - but in any case it is necessary that the knowledge and acceptance by the insured of this circumstance is clearly stated in the contract, either because it is stated in the particular conditions or because, although it appears in the general conditions, the clause appears duly highlighted and expressly accepted by the policyholder.

31VIVANTE, *Il suicidio*, cit., p. 13, was right when he stated: "although I consider suicide to be an evil, I do not believe that it can be effectively cured by civil and criminal law". In his opinion, since this decision would have been taken, the insurance policy is not only ineffective, but also harmful for several reasons.

32 Without going into cataloguing the suicidal act or the act that provokes and self-provokes this self-injury, the Spanish Supreme Court has considered as an accident for insurance purposes the shock for parents of discovering the death by suicide of a child. Thus, the STS of 15 July 2020, asserts and labels the psychic shock triggered as fit within the concept of "bodily injury" given by the law with respect to accident insurance, as it derives from a violent, external and sudden event, which we must define as an "accident". The dispute centred on determining whether the accident insurance policy taken out by the litigants covers the permanent disability that was declared to the insured after he was diagnosed with severe post-traumatic stress disorder and major depression, caused by the fact that he had discovered his only son hanging in his home, immediately proceeding to take him down and unsuccessfully providing the necessary aid in his capacity as a doctor, in spite of which the young man died in his arms. In the present case, the traumatic

its insurance, why does it nevertheless permit certain contours of suicide, at least in *abstracto*?[33] However, the Spanish law says nothing about palliative care, euthanasia itself, or assisted suicide[34]. The question is, how does suicide affect the insurance relationship in any of its phases or moments, whether in the pre-contractual phase, in the payment of the premium, in the aggravation of the risk and its communication, in the case of a frustrated attempt that causes injury to the insured, in the burden of proof, even in

event triggered a psychological shock in the plaintiff which, as well as being particularly virulent, was immediate, ascertained by the forensic doctor when the body was removed, and confirmed a month later by the report of the psychologist who examined the plaintiff.
The damage, therefore, was particularly intense, immediate to the causal event, not transitory, and subject to a progressively worsening evolution, in accordance with the nature of its own aetiology, which finally led, after one year and three months, to permanent disability due to a "non-occupational accident". However, this judgement had a dissenting dissenting vote by three judges who considered that the discovery, experience and internal assumption by the insured of the death of his son are not events that can be considered as an accident, as he was simply an eyewitness to what happened, even if it is in accordance with a psychological shock that generates a post-traumatic stress disorder, as a response to the negative experience.

[33] Of course, TAPIA HERMIDA, "Suicidio y seguro: la sentencia 514/2016, de 21 de julio, de la Sala Primera de lo Civil del Tribunal Supremo", [http://ajtapia.com/2016/09/suicidio-y-seguro-la-sentencia-5142016-de-21-de-julio-de-la-sala-primera-de-lo-civil-del-tribunal-supremo/] when he argues: "When the red line of the first of the human being's instincts, which is survival, is crossed, any attempt at rational understanding collides with unreason. Suicide is therefore one of the most profound and complex problems that human beings can deal with and which presents, like a kaleidoscope, a multitude of facets that are always difficult to treat with the respect and attention that the case deserves. One of them, which is particularly relevant for the relatives who must try to understand what is very difficult to understand, is the patrimonial aspect and, within this, the insurance aspect. In this sense, the basic rule is art.93 of the LCS which -within the regulation of life insurance- establishes: *"Unless otherwise agreed, the risk of suicide of the insured person will be covered from the passing of one year from the moment of the conclusion of the contract. For these purposes, suicide is understood to be the death caused consciously and voluntarily by the insured person himself"*.
The recent relationship between suicide and insurance is growing notably both because of the frequency of the phenomenon (statistics tell us that there are 10 suicides a day), and because of previous symptoms, such as the growing number of lawsuits on survival insurance - especially for mortgage loan repayments - in which the coverage of absolute professional incapacity caused by depression is disputed".

[34] Probably one of the most advanced legislations on this point is the Oregon legislation in the USA. Thus, Section 127.875 of the Oregon Revised Statutes in 2020, states: "The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Nor shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon life, health, or accident insurance or annuity policy.

the effects on compensation, etc.?[35]. Moreover, in the event of an insured taking his own life, would the heirs of the insured, but not the beneficiary as such, have the right to recover part of the premiums paid? There are, therefore, a priori, two levels on which to focus the question, that of coverage and that of compensation, if applicable.

There is no doubt that, in this first field, that of coverage versus exclusion, two clauses come into play above all, the clauses of incontestability, such as the pure or specific clauses of suicide, euthanasia, assisted death, palliative care, etc[36]. Beyond the legal dictate of the regulation where suicide is specified, even in a very generic way, either in its coverage or in its exclusion or its temporal conditioning, normally it is and will be the conditional clauses that, where appropriate, address the risk of suicide, euthanasia, assisted death, palliative care, etc[37]. For the time being, except for specific regulations

[35]On premeditation and the insurer's burden of proof, see, among others, VITAL DA ROCHA/GUIMARÂES, "O suicidio do segurado no contrato de seguro de vida: comentarios ao recurso especial 1.334.05/GO", Revista Duc In Altum Cadernos de Direito, 2017, vol. 9, n.º 18, pp. 33 ff, and that on p. 42 state: "voluntário o caso do suicídio premeditado, qual seja, aquele em que já se contrata o seguro pensando no autoextermínio, é possível se apontar como voluntário qualquer suicídio em que quem o pratica está no gozo de suas faculdades de discernimento, so that the choice of premeditation as the only criterion for determining whether or not the suicide was premeditated can be considered as a true doctrinal and jurisprudential option - but not a legislative one. The burden of proving that there was premeditation was on the insurer, which would have to demonstrate unequivocally that the insured had already taken out the insurance policy with the suicide in mind".

[36] On the incontestability clauses, we refer in depth to our work VEIGA COPO, Tratado del contrato de seguro, 7th ed.

[37] On this point, MORRIS, cit., p. 225 and 226 states: "Suicide clauses generally exclude coverage for death by suicide and insurers generally return the monthly payments made toward the policy's premium, at least for suicides that occur within the contestable period. Suicide clauses act as a deterrent for insureds who purchase life insurance with the intent to harm themselves. An issue arises when a life insurance policy includes both a suicide clause and an incontestability clause. Most courts hold that, if the suicide occurs within the contestable period, the suicide clause is simply a risk that is not covered under the policy. Thus, by denying coverage for suicide, the insurer is not "contesting" the validity of the contract, but rather, reading the suicide clause as a stipulation in the contract. The interpretation of the language in the insurance contract is strained when a suicide occurs after the contestability period has lapsed. Some courts hold the same viewpoint in this scenario as when the suicide occurs within the contestable period-i.e., the suicide clause is an exclusion from the policy and the insurer is not challenging the validity of the contract, but rather, is enforcing the terms of the contract. Still, courts are split on this issue, and some have held that the incontestability clause does not exclude suicide from its terms. In jurisdictions that do not exclude suicide from the contractual terms, the insurer is forbidden from denying payment for a suicide occurring after the contestability period".

such as that on euthanasia in 2021, nothing is said in the insurance regulations about these dimensions concerning their insurability.

In the context of personal insurance, not only in the case of life insurance in the event of death, but the questionnaire can also ask about hereditary background, cause of death of close relatives, medical questions, pathologies, etc[38]. But is it feasible to ask directly whether the insurance applicant and bearer of the risk has or has had suicidal tendencies or on some occasion tempted to do so? And if he intentionally conceals or distorts the reality and the information of suffering a terminal and incurable illness or suicidal intention or of requesting euthanasia or assisted death, would the insurance cover this contingency under the legal canons of article 93 LCS?[39] Or must they in any case respect, regardless of the normative scope of the clauses, the will of the insured for assisted suicide?[40] Are we ideally faced with two identical cases, i.e. suicide and assisted suicide?[41] Do those who commit assisted suicide due to suffering an irreversible and

[38]BLANDÓN CUESTA, cit., p. 9 states that suicidal ideation, parasuicide and completed suicide constitute a public health problem whose triggering motives present a multifunctional and complementary aetiological diversity that mainly affects young people under special conditions of biopsychosocial vulnerability. In the person with ideation, there is a rupture in the meaning of life, which in turn affects psychosocial robustness and generates an important fragility in the belief system, facilitating the emergence of new risk factors for suicide. Clinical studies reveal that impulsivity and pessimism are closely related to self-harm (Hawton et al., 2006; Hawton & Harriss, 2007; Gabilondo et al., 2007), whereby suicide, according to Blumenthal (1998), is caused by the "interaction and overlap" of five classes of factors: biological, personality traits, psychosocial or environmental factors, mental disorders, and family history and genetics. Likewise, Asberg, Thoren & Traksman (1976) found that suicidal behaviour correlates with decreased brain serotonin concentration, which is modified by psychosocial and genetic elements.

[39] There is no doubt of this insurer's refusal for MORRIS, cit., p. 226 pointing out how in addition to the limitations of cover expressed in the policy, insurers can annul insurance contracts by asserting the defences of concealment or misrepresentation. Both defences are based on common law principles of contract law. Concealment occurs when an insured intentionally fails to disclose "material information". When an insurer asks an applicant a question, the information is presumed to be material to determining the applicant's risk. Material information also includes any statements made by the applicant before the insurer issues the policy. But the American author also alludes to the request of independent medical reports that text the actual psychophysical health of the insured.

[40] This is the direction taken in some American state legislations. See MORRIS, cit., p. 230 et seq.

[41] On this point MORRIS, cit., p. 232, following Webster, points out that assisted suicide is legal in other respects if it is legally recognised: "PAS is an atypical suicide for a myriad of reasons. Merriam-Webster defines "suicide" as "the act or instance of taking one's own life voluntarily and intentionally". Although physician-assisted suicide involves the taking of one's own life voluntarily and intentionally, it also includes

incurable illness, therefore terminal, have per se the same time or probability of identical time as those who directly commit suicide without suffering such an illness?[42]

It is well known that one of the characteristics, even the main one, of the insurance contract is good faith and the bidirectional information that the parties must provide to each other throughout the insurance relationship, but can we talk about when the suicide is voluntary and when it is carried out maliciously if there is such a differentiation? and of good faith? In many suicides, if the insured who takes his own life lacks full awareness and knowledge of the illicit act he is committing, the action of taking his own life, nothing can be imputed to him[43]. But this is not always the case. Is the exclusion of the risk of

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two important caveats that distinguish it from that of a suicide in the common vernacular: (1) PAS is expressly legal in jurisdictions that have enacted right-to-die laws; and (2) these jurisdictions require the individual to be terminally ill, defined as having six months or less to live, to participate in PAS".

[42] At this point, he sustains this difference in life expectancy and life span in a terminally ill, healthy person's case, arguing, MORRIS, cit., p. 233 by stating: "Additionally, insureds participating in PAS differ significantly from other individuals who choose to end their own lives-a person participating in PAS has a set amount of time to live, whereas the life span of other insureds committing suicide is unknown. Because a terminally ill insured will perish within a limited time regardless of whether they participate in PAS, beneficiaries of the insured's life insurance policy should receive the benefits of the policy, regardless of contractual language to the contrary. By ruling otherwise, allowing suicide clauses to control whether beneficiaries of an insured participating in PAS receive their rightful benefits, courts would allow insurers to discriminate against those individuals who are terminally ill, thereby frustrating the purpose of right-to-die laws. *The purpose of the right-to-die laws is for terminally-ill individuals to choose their manner of death in a dignified, controlled manner; the purpose is not meant to defraud insurance companies.* Thus, the insurance policy's beneficiaries should not be punished for expedition of the insured's impending death through PAS, just as beneficiaries should not be punished for an insured's natural death. Whether the insured participates in PAS in order to die in a swift, dignified manner, or the insured perishes through the drawn-out, painful manner of a natural death, the insurer will nonetheless owe the insured's beneficiaries payment within six months. Therefore, because of the distinction between a "typical" suicide and PAS, and in conjunction with the legislative intent of right-to-die laws, suicide clauses should not apply to an insured who participates in PAS, despite policy language to the contrary".

[43]Closely following the criminalist Mezger, HALPERIN, Contract, cit., p. 521, pointed out that in order to exclude imputability due to the disturbance of consciousness, absolute loss of consciousness is not required; it is sufficient that there is a high degree of disturbance of consciousness and that self-determination is excluded, even if it is with regard to the special act. For the former, "disturbance of consciousness is disturbance of the consciousness of the self in relation to the consciousness of the external world". The latest edition of this work by the German professor, MEZGER, Tratado de derecho penal, [RODRÍGUEZ MUÑOZ (transl.)], Buenos Aires, 2010, vol. 2, pp. 66. He stated: "In cases of a high degree of disturbance of consciousness, the relationship of the self-consciousness to the self and to the external world is disturbed and interrupted, in such a way that the normal influence of the self on the external world is excluded; there

suicide, or that of overdose or drugs, a clause delimiting the insured risk or, on the contrary, a clause limiting rights and therefore requiring special incorporation characteristics to be enforceable?[44].

In addition, there is a whole plethora of questions, such as: Does life insurance cover the death caused by the insured? How is this coverage compatible with the axiom of malice or bad faith on the part of the insured, and how does voluntary suicide fit in with fault?[45], How does accident insurance relate to suicide, taking into account that the accident is a sudden and external event outside the intentionality of the subject?[46] What motivates an insured person to seek such coverage or even, a sensu contrario, to silence it, given that he may know that in Article 93 LCS, in any case after one year from the perfection of the contract, the risk of suicide will be the object of guarantee?

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is at most a partial consciousness, that is, the total self no longer intervenes, in these cases, in the process of the formation of the will".

[44]Key in this point is the Supreme Court ruling of 27 September 2017 in the case of a pedestrian who was run over and killed after having previously ingested a large amount of medication. The relatives sought to collect double compensation, one for death and the other for an accident resulting in death. The Court noted that the incorporation requirements had been met, both in the pro-medication clauses and in the exclusion clauses, which it considered to be restrictive, also stating, in relation to the alleged error in the assessment of the evidence regarding the consumption of drugs and the intentionality of the deceased, the Court points out that both points must be understood to be accredited on the basis of the documentary evidence of the chemical toxicological study, the report drawn up by the Guardia Civil de Tráfico and the testimony of the drivers who were passing by the place and directly observed the deceased's conduct, which means that this possible error of assessment is also dismissed. For LANDINI, "Art. 1927", cit., p. 297, we would be faced with a delimitation of the risk that, as is the most recent practice, of excluding voluntary suicide, including culpable suicide, if it takes place in the first two years of the stipulation of the policy or, after this period, in the first twelve months from the eventual reactivation of the contract.

[45]On this point SALANDRA, *Dell'assicurazione,* Commentario al Codice Civile, [SCIALOJA/BRANCA)], Bologna, 1966, p. 427, who, in relating suicide to the insurability or not of the fault ex art. 1900 of the Codice, stated that in the case of suicide, the legislator "specifically contemplating the hypothesis of suicide, evidently wanted to "sottoporla" a special system, imposed by particular considerations, among which that of the difficulty of the voluntariness or otherwise of the suicide".

[46]SALAS CARCELLER, cit., [electronic resource] insists on this point, recalling how art. 102.2 LCS, for the case of accident insurance, establishes that if the insured intentionally provokes the accident, the insurer is released from the fulfilment of his obligation. An adequate interpretation of both regulations seems to demand that if the insured person dies in the accident - which, in reality, ceases to be so if it is intentionally provoked by the victim himself - it should be considered suicide and, if there is also life insurance, it should be adjusted to the discipline of the same.

Does suicidal behavior respond psychologically to a deliberate act, which is always conscious and desired by the subject? It is not entirely correct to say that it is merely a question of volition, to which more factors must be added[47]; is there a part of the population more prone to suicide, can we speak of genetic, racial, or biological inheritance issues with regard to suicide and therefore be predictable for insurance from an actuarial point of view, how does selfish suicide, altruistic suicide or anomic suicide - the latter related to economic crises - influence insurance cover?[48], What about suicide by contagion?[49]; should an insurance applicant or policyholder be aware of cases of

[47]BLANDÓN CUESTA, cit., p. 10 confirms this point of view when he states: "Suicide is an activity that is related to volitional processes, but is not reduced to them; therefore, it is a choice mediated by neurobiochemical and neuroendocrine conditions, as well as by triggering psychosocial circumstances".

[48]Thus, with regard to anomic suicide, DURKHEIM, cit., p. 321, stated that it is a well-known fact that economic crises have an aggravating influence on the tendency to suicide.

[49] Addressing "Suicide Contagion" DUGDALE/LERNER/CALLAHAN, "Pros and cons of Physician Aids in Dying", 2019, [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6913818/], point out that "The sociologist David Phillips first described suicide contagion in the 1970s. He showed that after high profile suicides, society would witness a broad spike in suicides. This was particularly true for individuals whose demographic profiles were similar to those of the person who died by suicide. Although Phillips's work did not focus on AID, it has been corroborated recently by the spike in youth suicidality following the airing of Netflix's *13 Reasons Why*.

The publicly-available data from Oregon, however, reveal that in the months surrounding Maynard's high-profile death in November 2014, the number of similarly situated individuals in Oregon who ended their lives by lethal ingestion more than doubled. Furthermore, from 1998 (when Oregon started recording data) to 2013, the number of lethal prescriptions written each year increased at an average of 12.1%. During 2014 and 2015, however, this increase doubled, suggesting that high-profile AIDs leads to more AIDs. Although the data do not prove that an increase in AIDs causes more non-assisted suicide, a study by Jones and Paton found that the legalization of AIDs has been associated with "an increased rate of total suicides relative to other states and no decrease in non-assisted suicides". They suggest that this means either AID does not inhibit non-assisted suicide or that AID makes non-assisted suicide more palatable for others.

Slippery Slope.

Some opponents of AID express concern that once doctors are involved in the business of hastening patients' deaths; they have already slid down the slippery slope. Others suggest that the slope is best exemplified by an expanding list of reasons for electing AID. Refractory physical pain is no longer the most compelling reason for ending one's life through lethal ingestion. Instead, cumulative Oregon data suggest that the vast majority of patients elect AIDs because they are concerned about "losing autonomy" (90.6%) or are "less able to engage in activities making life enjoyable" (89.1%). Some fear a "loss of dignity" (74.4%); being a "burden on family, friends/caregivers" (44.8%); or "losing control of bodily functions" (44.3%). Concern about inadequate pain control was the reason for pursuing a lethal ingestion in only 25.7% of cases.

Opponents also point to increasing calls in the US for euthanasia. In 2017, Senate Bill 893 was introduced to the Oregon State Legislature; it would have enabled patients to identify in a legal directive the person they wished to administer their lethal medications, effectively legalizing euthanasia. Although this bill

suicide in the family of the risk carrier, should the insurance technique identify and isolate any extra-social factors that may influence the suicide rate, is there a risk of a suicide mimic effect that increases the suicide rate? Is suicide related to an economic crisis, marital anomie, divorce, etc.?[50], Can debts or ruin, and insolvency, be the trigger for such

failed, the Oregon House passed HB2217 in 2019, which expanded the definition of "self-administer" to include options in addition to the oral ingestion of lethal drugs. The House also put forward HB2903, which seeks to expand the word "ingest" for lethal medication to "any means" and also proposes to expand the definition of "terminal disease" to include "a degenerative condition that at some point in the future" might cause death. It remains to be seen whether Oregon will become the first state to legalize euthanasia.
Although Belgium and The Netherlands permit both AID and euthanasia, the latter dominates. Over the years there has been a steady increase in acceptable criteria. Currently, patients who suffer from depression, dementia, or being "tired of life" may be euthanized. In some cases, minors may also be euthanized [18]. Published data from the Flanders region of Belgium highlights that vulnerable populations are especially likely to be euthanized. From 2007 to 2013, the largest increases in rates of granting euthanasia requests were among women, those 80 years or older, those with lower educational achievement, and those who died in nursing homes".

[50] On suicide and financial problems, see the suggestive article by MUÑOZ PAREDES, M.ª. L., "Suicidio por problemas económicos y seguro de vida", blog almacén de Derecho, entry of 7 October 2016, regarding the STS of 21 July 2016. For SALAS CARCELLER, cit., in life insurance, the cases brought before the courts have generally referred to cases in which the reticence or inaccuracies in the declaration of the risk affected the state of health of the insured, family history, etc. and not the economic situation that could lead one to think of the possibility of suicide for this reason. In a certain way it seems offensive to morality that an insurer, when taking out life insurance, does not exclude the suicide of the insured from coverage - as it can do for cases of death in the exercise of dangerous activities such as mountaineering or car racing - and nevertheless asks about his economic situation in anticipation that there could be a greater risk of suicide, which is nevertheless covered by the insurance cover. Also TAPIA HERMIDA, "Suicidio y seguro", cit., who describes the judicial iter of the case, viz: Mr. X took out, on 15 April 2009, a life insurance policy with a capital cover of 1,500,000 euros in the event of the death of the insured. Beforehand, he filled in the application form for the insurance policy in which he did not indicate a desperate financial situation and in which he did not leave a record of any family history of suicide.
On 20 April 2010, Mr. X committed suicide leaving a note in which he alluded to the commission of the same *"to help my family get ahead"*. The insurer denied payment of the insured capital to the widow and children of the deceased on the grounds that art.10 of the LCS was applicable, as it considered the insured's fraudulent intent in the declaration of the risk prior to the formalisation of the policy, alleging - as data concealed by the deceased - those relating to his economic situation as well as the existence in the family of other cases of suicide.
The widow and the two children of the deceased filed an ordinary lawsuit against the insurer requesting that it be ordered to pay €500,000 to each of the three beneficiaries and, as a whole, €1,500,000, plus the interest accrued until the date of payment in accordance with the provisions of Article 20 of the LCS and the costs. The claimants submitted to the proceedings, among other evidence, an expert report.
The insurer replied alleging the deceased insured's fraudulent concealment of the aforementioned circumstances and provided, among other evidence, an expert's report and the deceased's tax declarations to the AEAT.
The Court of First Instance no. 5 of Alcalá de Henares handed down a judgment on 25 October 2013 in which it dismissed the claim on the grounds that the deceased's financial situation was, to say the least, compromised and that he concealed relevant data when filling in the insurance application form.

a decision?[51], what about obsidional or collective suicides?[52]. Is there an imitation or contagion of suicide when a leader, celebrity, etc., commit suicide and then several people imitate this behaviour? To what extent does the propensity to commit suicide depend on economic and social considerations or evaluations in a culture?[53], suicide with illnesses that are not necessarily mental, and with psychic pathologies or psychopathologies? Who is more prone to suicide, men or women?[54] , young people or adults? do climatic, seasonal, religious, social, etc. factors influence the propensity to suicide? who takes out a life insurance policy and wants suicide cover already has the intention to commit suicide or

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The 10th Section of the Provincial Court of Madrid handed down a judgement on 24 June 2014 in which it upheld the appeal of the beneficiaries of the insurance and upheld their claim on the understanding that there were contradictory reports, which were based on different assessment criteria, without the court having other sufficiently convincing evidence to attribute greater credibility to one or the other report. Therefore, it considered that the veracity of the data provided by the insured to the insurer prior to taking out the insurance contract had not been disproved and that, therefore, outside the merely speculative sphere, neither was it accredited that the insured had taken out the insurance a year before with the aim of committing suicide.

[51]There have been cases of financial ruin and bankruptcy that have led to the entrepreneur's suicide. A well-known case was the one judged by the Court of Senna on 12 May 1876. A banker who went bankrupt had taken out two separate life insurance policies with different companies on behalf of his spouse and children. Shortly after going bankrupt, he committed suicide. Both his widow and the bankruptcy trustee demanded that the insurers pay the compensation. The insurers refused because of the voluntary suicide of the bankrupt. For the court "... it follows from all the circumstances accompanying the death that the death of the insured cannot be attributed to anything other than a voluntary suicide".

[52]DURKHEIM, *Suicide*, cit., p. 153 et seq., among the collective suicides with the greatest impact and most recent knowledge occurred in Guyana in November 1978 when 914 people took their own lives at the same time. All belonged to the "people's temple" sect and followed the leadership of a reverend. Experts hesitated to classify these events as either mass suicide or mass murder.

[53]Key is the study by CHEN/CHOI/SWADA, "Those Who Are Left Behind: An Estimate of the Number of Family Members of Suicide Victims in Japan", CIRJE Discussion Paper, 2008, CIRJE-F-604, www.cirje.e.u-tokyo.ac.jp, also in Social Indicators Research, 2009, no. 94, vol. 3, pp. 535 ff, where they analyse suicide studies presenting procedures and their estimates of the number of family members who lose loved ones to suicide. Using Japanese aggregate-level data, three main findings emerge: first, there are approximately five bereaved family members by suicide; second, in 2006, there were approximately 90,000 children who had lost a parent to suicide; and third, in 2006, there were about three million living family members who had lost a loved one to suicide. The direct production loss of immediate family members of a person who had committed suicide in 2006 alone is estimated at approximately $197 million. These results are valuable for assessing the cost-effectiveness of suicide prevention programmes and for designing appropriate policy instruments.

[54]ILARDI, "Il "rischio suicidio" nel contratto di assicurazioni vita", Foro it., 1935, IV, pp. 203/204 ff, pointing out on p. 204 how the statistical revelations showed great oscillations in the results, giving in fact the measure of the divergence that could be verified between the average duration of the insured's life, which is indicated in the mortality tables, and the alteration that suicide, due to non-natural causes, entailed.

take out the policy for that sole purpose? who takes out a life insurance policy and wants suicide cover already has the intention to commit suicide or take out the policy only for that purpose? Is the insured who takes his or her own life in this action in breach of any kind of contract with the insurer, suicide or accident and burden of proof, suicide or accident and burden of proof?[55].

Let us also consider the case in which the policyholder or risk carrier is aware that he/she suffers from an incurable or terminal illness and that, when taking out the insurance policy, this is made clear to the insurance company, also providing diagnoses and medical tests as well as treatment. The insurer decides to perfect the insurance and the hypothesis can be twofold, not covering palliative care, health care after death or euthanasia, if necessary, with its confirmation in the clauses, or its silence in the same on the one hand, or, on the other hand, that the policy does specifically cover those extremes[56]. And to this

[55]For the ruling of the High Court of Justice of Andalusia of 10 January 2019, it considers the suicide of a bank employee due to the stress caused by an argument with a client to be an accident at work. According to the ruling, there is a clear causal relationship between the facts and the tragic end, so that it is presumed to be an accident at work, and it is irrelevant whether the act of taking one's own life is voluntary, given that voluntariness in these cases is not conscious. The worker had no previous psychiatric illness or outbreak, so, given the continuity of the events, a strong argument followed by suicide, he decided to throw himself off the roof of the building, so it is considered that the events were directly related to work.

[56] MORRIS, cit., p. 231 when he states: "Assuming that the applicant truthfully discloses knowledge of a terminal illness, the insurer would likely engage in reverse adverse selection to refuse to sell insurance to the person. In this case, the applicant has no claim against the insurance company because the insurance company can refuse to sell insurance to high-risk persons if it so chooses.

Conversely, a problem may arise if the insurance company decides to insure the terminally ill person, although this situation is highly unlikely. Since the PAS laws consider a person with less than six months to live to be terminally ill, an insured who participates in the

PAS will, of course, commit suicide within this period.

If this situation occurs, the insurer can challenge the validity of the contract to try to avoid payment to the beneficiaries of the policy. The insurer may also attempt to void the policy under the doctrine of fortuitous event. To defend against such a claim, the policyholder can invoke two defences: waiver and estoppel. The policyholder can assert a defence of waiver by arguing that because the insurer knew of the existing illness based on the policyholder's responses to the insurance application and the results of the insurance application and the results of the individual medical examinations, and because the insurer voluntarily accepted the risk.

The policyholder can claim that, by the insurer issuing a policy despite the known risks, the policyholder relied to the detriment of the insurer's conduct by paying the premiums and not seeking other insurance. In this case, the policyholder can argue that the insurer cannot cancel the policy.

supposition let us add another one, the potential insured person, aware of his terminal and incurable illness, nevertheless hides these facts from the insurer who does cover the risk of death in the insurance policy. Would he be insured? What with an incontestability clause and the period of possible challenge if it is proven that the insured acted in bad faith by concealing or *misrepresenting* such a fact, even though there was not even an ad hoc question on this issue in the questionnaire, but a generic question on illness which should, in any case, be answered by the applicant for insurance?[57] And the final question: if the right to a dignified death is recognized, should the insurer, in any case, admit and therefore not exclude from coverage the participation of its insured in a medically assisted death or suicide procedure?[58].

This is different when the insured person is diagnosed with a terminal illness and asks for euthanasia or assisted death. Does the insurance cover the death resulting from such an

[57] MORRIS, "A right to die", cit., p. 234, argues that the insurer may claim that the policyholder concealed a material fact in bad faith by omitting information that was specifically requested in the application for insurance. Because the insurer specifically included questions about the insured's health and welfare, the information is presumed to be material to the insurer's decision to perfect and issue an insurance policy to the policyholder. This defence is limited depending on the facts of the case. For example, if the policyholder simply omitted a question from the policy, the policy is prima facie incomplete, and it is obvious that the insurer should not rely on the request before issuing the policy. In this case, the policy would not be subject to cancellation. However, if the policyholder answered all the questions, but omitted the terminal illness in an answer with which the terminal illness in an answer with which he or she should have reported the terminal illness, the insurer can assert the defence of concealment. Thus, a reasonable insurer would be deceived if the policyholder lied about the insured having the illness, the insurer could void the policy within the contestable period.
Thus, a reasonable insurer would feel misled if the policyholder omitted information that was asked about in an apparently complete application and could therefore assert this defence during the contestability period. In addition, the insurer could assert the defence of misrepresentation if the policyholder has submitted false information in the policy by affirming or denying statements. Thus, if the application for insurance asked a question that required the policyholder to disclose the existence of a terminal illness, and the policyholder lied that the insured had contracted the illness, coverage could be declined.

[58] MORRIS, cit., p. 238 supports that coverage by arguing: "language requiring insurers to comply with the insured's choice to participate in the PAS is imperative as more states adopt PAS laws. Aside from the unpredictability, time and associated costs of litigation, failure to adopt language explicitly requiring insurers to honour the insured's insurance contract, regardless of their participation in PAS, carries significant public policy implications. For example, a simple suicide clause within the policy could void the policy entirely if the insurer decides to challenge the validity of the contract. This potential implication is of particular concern in Montana, which is the only state that has adopted PAS through state common law.

event in this case? The assumption is clear, i.e. the policyholder or insured person is unaware of the existence of a terminal illness in the risk carrier - the Risikoträger - or it is even discovered after the insurance has been finalized and confirmed. Moreover, we are not in any case under the assumption of an alleged aggravation of the risk, since illness is a connatural part of human beings and can appear suddenly at any time, which is not considered to be aggravating in life or personal insurance policies in general. Another question is whether contact, work, etc., with certain materials, work environments, etc., would be more prone to the development and appearance of illnesses[59].

Suicide

Unfortunately, in the case of suicide, we are faced with one of the facts that, without being cancerous and cardiac diseases, represent more deaths, reaching in the case of Spain the chilling figure of ten or eleven deaths per year due to this cause[60]. It has become the main cause of unnatural death. In addition, there is a connection between unnatural but voluntary death and, in some cases, intentional insurance fraud[61]. A cause of death that

[59] For MORRIS, cit., p. 235, this fact does not imply any concealment or misrepresentation given that the policyholder or insured are unaware of the existence of this illness, and therefore the North American author opens the way to the coverage of an assisted suicide. He states that, in this case: "The insured has committed suicide within the policy period. Therefore, courts faced with the question of whether to apply a suicide clause in the case of PAS should decide that the suicide clause is unenforceable based on the public policy surrounding the purpose of PAS: that the terminally ill may choose their manner of death in a dignified and controlled manner". A contrary ruling would allow insurers to discriminate against the terminally ill, thereby frustrating the objectives of right-to-die laws, which allow the terminally ill to choose a dignified and controlled death rather than suffer a dreadful terminal illness.201 Moreover, as those who can participate in the death, hastening the death of the insured should not affect the decision of the insurer who must pay the sum insured to the beneficiaries of the policy; the insurer will, however, owe the policy benefits within six months, regardless of whether the insured has died, and decided to participate in the PAS.
Thus, because PAS is distinguishable from a "typical" suicide, and based on the legislative intent of the right-to-die laws, suicide clauses should not apply to an insured who participates in PAS, regardless of policy wording to the contrary.

[60] In 2015, 3602 people took their own lives in Spain. https://elpais.com/elpais/2017/06/12/ciencia/1497291180_123865.html. In 2017, 3679 people committed suicide. By autonomous community, Asturias has the highest suicide rate in Spain.

[61] NICOLAS, *Droit des contrats d'assurance*, Paris, 2011, p. 695, alludes to this possible intentional fraud against the background that the insured capital may constitute an incitement to suicide.

also affects all age groups and where effects such as COVID-19 confinement measures have led to a very high number of suicides among people aged between 15 and 29. 2020 was a year in which 3914 alleged suicides were officially registered, 7.4% more than the previous year[62].

Indeed, the exegesis of the article of the LCS allows the coverage of this contingency, just as it tolerates exclusion. Does the temporal taxability of requiring the passing of a mere time interval, so that at least periods of cover have been paid through the premium, perhaps suppose an implicit sort of suspension of the insurance contract in the event of death occurring as a consequence of the suicidal action of the insured?[63]. This is an insurable risk, but also one that can be excused by the insured entity a priori. A risk that, in a certain way, dilutes the innate instinct of the human being to survive. It is a different matter whether or not this conduct, this suicidal behavior which supposes the generation by the insured of the damaging fact or event, is covered by the insurer, or can be excluded in any case, although on this point, doctrine and jurisprudence soon drew a thick line between the conscious and the unconscious, or what is the same, the voluntariness or, precisely the deprivation of the same when taking one's own life[64].

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[62] https://www.elmundo.es/espana/2021/11/12/618d7d7021efa0875b8b45f7.html. Where it says: "The Covid crisis is a contextual risk factor that adds to the multi-causality of suicide. Covid does not generate suicide, it is an additional factor. And, that said, the pandemic has affected the risk factors we already knew about and has threatened protective factors, such as social cohesion. We will need more years to empirically prove that Covid has an influence. The hypothesis is that it does. But it is not inevitable. There is still time. State plans and prevention policies need to be adopted now.

[63]LANDINI, "Art. 1927", cit., p. 296 when he states that the policies also provide for derogations introducing mere suspensions of cover in the first year for cases of suicide, where it is foreseen that the event of death by suicide is not covered by the insurance guarantee in the first two years from the stipulation of the policy or from the day on which the suspension of the policy ceased due to non-payment of the premium.

[64]TAYLOR, *cit.*, p. 26, points out that if the policy was taken out "with the express idea of killing it by suicide", the courts have denied "recovery to the claimant".

Beyond voluntariness

Despite this instinct to live and survive, human beings can decide at any given moment to take their own lives. A person voluntarily decides to commit suicide. Fully aware of his decision, he carries it out, but is suicide always voluntary?[65]. Or does he or she enlist the help of others to carry out this self-injury? In the face of the abnormality of such behavior for human beings and society, a clear and self-justifying duality has always existed: voluntariness or intentionality, as opposed to the involuntariness of the subject. This is precisely the way in which the risk of suicide is admissible, without any questioning or questioning of any kind: does insanity, for example, not operate as an uncertain or fortuitous event in the case of the insured's suicide?[66]. It did not matter to draw a ductile and to some extent imaginary barrier, namely the consciousness or unconsciousness of the one who takes his or her own life in the act or action of taking his or her own life[67]. Intentionality versus unconsciousness or unwillingness or actual knowledge of what is being done[68].

[65]BADO, "El suicidio", cit., p. 113 when he states: "Suicide is, by nature, voluntary, which is why we prefer the expression "conscious" suicide or "unconscious" suicide. Thus, conscious suicide is the act by which the insured takes his own life in full use of his faculties. This fact undermines the obligation of the insurer as it violates the principles of the insurance contract. In our opinion, it is with respect to this kind of suicide that the ground of nullity applies. Suicide is a ground for nullity if it is the result of the conscious and clear will of the person involved".

[66]STIGLITZ, "Suicidio voluntario", *Temas de Derecho de Seguros*, Bogotá, 2010, pp. 215 et seq., p. 220, states how the requirement of voluntariness excludes the hypothesis of the suicide of someone whose mental faculties are altered, since in this case dementia operates as a fortuitous and uncertain event and, therefore, insurable.

[67]HALPERIN, *Contrato de seguro*, 2nd ed., cit., p. 521, admitted that the exclusion of the guarantee could also be agreed in the case of suicide committed in a state of unconsciousness; this being therefore a perfectly legitimate limitation of the risk in the opinion of the Argentinean treatise writer.

[68]The old jurisprudence did not shy away from comparing and calling for the penal theory of the intentional act in cases of voluntary suicide. Classical contributions by ALTAVILLA, "Il suicidio e l'art. 450 cod. Comm.", Ass., 1934, II, pp. 2 ff; ALIMENA, "Il suicidio nelle assicurazioni sulla vita", Ass., 1935, I, pp. 191 ff.

However, is it in any way admissible for the suicide of the insured person to be considered as a cause of nullity of the insurance contract?[69], does the suicide who consciously and voluntarily takes his own life also have the intention, or did he deliberately do so at the time of the conclusion of the insurance contract, to defraud or deceive the insurer, and is death cover taken out for this reason alone? We do not think so. Even if in the past there have already been cases of suicide attempts by the insured himself, all of which were frustrated.

In a certain sense, the question is relegated to a political and commercial decision of the insurance company itself, which can include or exclude self-inflicted death, or self-inflicted death. What is the real cause of death when it is not clear whether it is suicide or accident, and on what basis and what attitude will the insurer take?

This decision is not free of ethical and medical questions, but it has also been helped by the lack of visibility, if not awareness in society as if it were a pandemic, of this kind of death[70]. Trying to understand, or even comprehend and shape the causes that lead a person to take his or her own life is one of the most complex issues that a human being, as a person, must face. Even more so when it is a matter of close relatives or family members.

Economic and patrimonial questions are left aside, including the existence or not of insurance and the problem of its conditional coverage, as it is precisely at this point where

[69]This is not an isolated question. On the contrary, it has been the subject of doctrinal interest. See the contribution of BADO, "El suicidio como causal de nulidad del contrato de seguro", Revista de la Facultad de Derecho de la Universidad de la República, 2003, n.º 22, pp. 109 and ff.; previously, HALPERIN, *Contrato de seguro*, 2nd edition, cit.

[70]The Werther effect, a term coined by sociologists to define the imitative effect of suicidal behaviour, or, in other words, the avoidance of contagion, has long been argued. In 1774 Goethe published the novel "*The Sorrows of Young Werther*", in which the protagonist ends up committing suicide for love. Shortly after this publication, forty young people take their own lives in a similar way to the protagonist. A classic sociological study is Phillips, "The Influence of Suggestion on Suicide: Substantive and Theoretical Implications of the Werther Effect", American Sociological Review, 1974, vol. 39, no. 3, pp. 340 ff. From the point of view of sociology itself, there is no one better than DURKHEIM (cit., pp. 141 ff.) when he discusses imitation in suicide. On p. 153 he is categorical in stating: "There is no doubt that the idea of suicide is communicated by contagion".

suicide insurance comes into play. The condition of involuntariness, of unconsciousness or non-imputation to the subject of the act being committed has prevailed and continues to prevail in our culture[71]. There is an aura of moral and social reprobation in the face of behaviour that is highly individual and, in the eyes of that same society, selfish. Taking one's own life as an antithesis to the most primary instinct and element of the human being, life, survival, hence the predominant justification has been none other than involuntariness, illness, disorder, etc., which relativises the possibility of a conscious, wanted, and desired suicide on the part of the person who commits it[72]. It is in this parameter that we must place the insurance, which is based, moreover, on the non-imposition of this cover by the insurer[73]. It is a dispositive rule that therefore avoids the imperativity of the law of the insurance contract[74]. A rule of dispositive law, even though

[71]BADO, "El suicidio como causal de nulidad", cit., p. 115, is right when he states: "In a case of suicide, the most reasonable thing to do seems to be to analyse whether we are dealing with a conscious suicide or an unconscious suicide. If it emerges from the insured's medical history, or from other strong evidence, that he suffers from disorders, psychological or physical, which disturb his reasoning, the suicide can begin to be considered as a consequence of an illness. A revealing evidence of suicide as an illness is the recurrence of suicidal intentions of the insured person.

[72]Graph HALPERIN, *Contract*, cit., p. 520 when he pointed out: "the requirement of voluntariness is implicit in the law, because it is inherent to suicide, since that committed in a state of unconsciousness or state of mental disturbance is a fortuitous case". For his part, LANDINI, cit., p. 296 affirmed that voluntary suicide is only suicide carried out with full consciousness and freedom, and therefore it would not be that committed for reasons (passion, business or illness) which would have forced the insured, even if only from an emotional point of view, to carry out the extreme gesture. Suicide in these cases would also be covered by the insurance guarantee.

[73]Attributing the burden of proof to the insurer, HALPERIN, *Contract*, cit. p. 524 pointed out that "in case of doubt, suicide being an extraordinary and abnormal gesture, which conflicts with the instinct of self-preservation, it must be decided against its existence".

[74]This has not been a particular or specific feature of our legal system. The lineage is also produced with other countries, or rather it used to be produced, as in the Italian case. Thus, GASPERONI, "Assicurazione sulla vita", *Assicurazioni private (Scritti giuridici),* Milano, 1972, pp. 735 et seq, p. 741 already went into how the abrogated code freed the insurer from payment if the death of the insured occurred as a result of voluntary suicide, but legal interpretations and jurisprudential and doctrinal discussions have determined that suicide, as self-determination of the claim, under the reflection of serious psychic disturbances or force majeure and of distinctions between capacity and will, could avoid such uncertainties, could escape such uncertainties caused by interpretative subtleties, the companies derogated from the system of the code and excluded from cover all forms of risk covered in any type of suicide, including involuntary suicide, the most frequent in practice, for a given period of time. Thus, the assumption of any risk of suicide was intended to avoid the conclusion of contracts ordered prior to the suicide of those who deliberately intended to take their own life in order to profit the beneficiaries with the sum insured. It is true that, with time, policies have appeared that assume the risk of suicide as long as a certain period of time has elapsed

the law implicitly declares that suicide insurance is licit by conventionally permitting its coverage[75].

It is undeniable that apart from the intrinsic durability of human life, own or foreign, external or endogamous, causal or fortuitous, ordinary or exceptional events, but also the period in which they take place, i.e. life-long thresholds or, on the contrary, limited to more limited temporal units, condition and base the insured risk on the selection, the anti-selection, between the schemes of adversity and that of a minimum, at least, speculation. This last term must inevitably be reconciled with the principle of indemnity and the possibility of multiple and independent insurability of insurance on life and the human person[76].

But how can a risk carrier with suicidal tendencies be discovered, should an insurer knowingly bear the risk of suicide if an insured or a third party on whose head the risk

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uninterruptedly, but the ambiguity now came from the interpretative hand of which was the *dies a quo* for the computation of time, whether that of the conclusion of the insurance contract or that of the date of its reactivation in such a way that the contract itself had been in force for the time requested in the period immediately prior to the suicide. GASPERONI points out, as for the Court of Rome, in its judgement of 22 October 1943, this time should be calculated from the date of reactivation.

[75]ELGUERO Y MERINO, *El contrato de seguro de accidentes,* Cizur Menor, 2013, p. 189, does not expressly refer to whether or not suicide insurance is feasible in accident insurance. In this insurance, suicide could be a cause for exclusion of cover, depending on whether or not said suicide is the result of a volitional act of the insured or whether there are circumstances that allow for the assumption of a lack of sufficient mental capacity to assume cover. The STS of 20 November 1991 [RJ 1991, 8468], denied accidentality in a case in which the insured person killed himself without being in a pathological mental situation that affected the voluntariness of his acts. The insured was found at the bottom of the port of Valencia with a rope tied around his neck and knotted to a concrete block. The autopsy revealed violent death and death by immersion without the intervention of third parties being proven. For the judgement of the Audiencia de Barcelona of 29 March 2000 (AC 2000, 4588), knowing the aetiology of the death of the insured, if the death had been self-inflicted, it would be a clause of exclusion of coverage in the accident policy. As the necessary conviction had not been reached and considering that faced with the dilemma the insurer was obliged to prove his assertion of suicide, the insurer was ordered to pay compensation.

[76]Thus, POÇAS, *O dever de declaraçâo inicial do risco no contrato de seguro,* cit, p. 726 affirms how the potentially speculative nature of the contract can lead the policyholder to take out several insurances on the same risk with different insurers, so that the existence of a plurality of insurances, whose added capital sums reach large values, can indicate a "fraudulent intuition", either through the knowledge and concealment of facts that significantly increase the probability of death, or through the intentional production of the loss, such as self-mutilation or suicide.

hangs manifest suicidal tendencies? Certainly, a tendency is not insured, they are facts, but they can predispose to these. But can questions be asked in the questionnaire as to whether the insured has shown suicidal tendencies or whether a family member has been suicidal or has committed suicide?

And the fact is that in personal insurance, whatever its types or modalities, the event always has a typical harmful character[77]. There is no denying a certain difficulty, at least initially, in trying to dissect according to certain parameters what may be an attempt to classify life insurance and personal insurance in general, in which the subject of suicide has always been present[78].

There is no doubt that the treatment of suicide has a direct bearing on the delimitation of risk - objectively, subjectively, spatially - in relation to causes of death, in the same way as homicide[79]. But has it or does it do so concerning suicide assisted by a health professional? But also, in the contestability or, on the contrary, deferred incontestability in the pre-contractual phase of the declaration of the same[80]. Can a person who has concealed a suicide attempt, or a family history of suicide, or who suffers from certain

[77]BESSON, "Assurances", *Traité pratique de droit civil français*, XI, 2nd ed., Paris, 1954, pp. 611 et seq., p. 803 when studying the role of life insurance, stated that "for most of the older authors, life insurance was in principle, like property insurance, a contract of indemnity. It is certainly from the hypotheses of insurance in the event of death that this conception has the apparences for it".

[78]Let us also consider the peculiarities of each branch, or of each group of insurances. Thus, even at the time, LEVI, *L'assicurazione sulla vita,* Feltre, 1911, pp. 23 ff, already listed 12 contracts typologically in life insurance. Later, DONATI, *Trattato del diritto delle assicurazione private,* III, Milano, 1956, p. 572, established a typology of 21 life insurance contracts; more recently BAZZANO, *L'assicurazione sulla vita,* Milano, 1998, pp. 30 ff., distinguishes up to 28 different life insurance contracts.

[79]MAGGE, *Life insurance*, cit., p. 349, stated that suicide is considered "one of the hazards covered by the life insurance policy", emphasising the enormous difficulties of drawing a line between "sane and an insane" suicide.

[80]LA TORRE, *Le assicurazioni*, 4th ed., Milano, 2019, p. 502, reminds us that already in the old code the question of deferred incontestability was key. Indeed, "it is assumed the risk of any suicide (voluntary or not), but, in the event that such a person does not already have the purpose for which he is insured, it is appropriate that for a certain period of time, called "period of grace",.... the risk of suicide is totally excluded".

psychiatric depressive pathologies, benefit from incontestability?[81] It is obvious that the death of a person is either due to natural causes or human causes, as well as natural causes or accidents[82]. But, unequivocally, is "every suicide is always voluntary, but it can be conscious or unconscious"?[83] In the latter case, we are dealing with hypotheses of homicide if they are caused by third parties, but we are dealing with suicide when the death is caused, provoked, by the victim himself[84].

In all lines of insurance, in every form, interest is present. It will be more direct and immediate, or more abstract and indirect. It is also present in personal insurance[85]. It is

[81] Again MORRIS, "A right to die", cit., p. 225 when stating how most courts hold that, if the suicide occurs within the contestability period the suicide clause is simply a risk that is not covered by the policy. Therefore, by denying coverage for suicide, the insurer is not "contesting" the validity of the contract, but rather interpreting the suicide clause as a stipulation of the contract.
The interpretation of the wording of the insurance contract is strained when the suicide occurs after the contestability period has expired. Some courts take the same view in this case as when the suicide occurs within the contestability period of the policy and the insurer is not contesting the validity of the contract, but is enforcing the terms of the contract.
In jurisdictions that do not exclude suicide from contractual clauses, the insurer is prohibited from denying payment for a suicide that occurs after the contestability period.

[82]Analysing the treatment of insurance and suicide in the 19th century and its decriminalisation, FORTUNATI, "Il dibattito sul suicidio dell'assicurato tra Ottocento e Novecento", cit. p. 10: "Cosa si intendeva per suicidio? Quale era il confine fra suicidio volontario e patologico? Quali i mezzi per discernere le due ipotesi? How to demonstrate that a man who commits suicide is conscious, in full possession of his mental faculties? Ed ancora: la volontarietà era un limite invalicabile nell'escludere la responsabilità dell'asicuratore o lasciava spazio a scelte diverse?".

[83]KULLMANN, "Suicide et assurance: une déjà vieille notion, mais un tout nouveau régime", RGDA, 2002, n.º 4, pp. 907 and ff, p. 908. For whom the very notion of suicide is based on the voluntary nature of death. Author who will analyse the assumption of suicide on the basis, firstly, that it is always voluntary and, secondly, that it can be consciously, but also unconsciously provoked. Already in Belgian law, the old insurance regulation of 1874 distinguished between voluntary (or conscious) suicide and involuntary (or unconscious) suicide. BINON, *Droit*, cit., p. 464, who points out that suicide is often presented as a particular form of intentional (voluntary) loss, provoked by the insured himself. FONTAINE, *Droit des assurances*, 5th ed., no. 391, questions whether or not a serious state of depression, medically assessed and confirmed, is included in this voluntary nature, as is also the case in cases of irresistible force.

[84]BADO, "El suicidio", cit., p. 113, recalls that "suicide is, by nature, voluntary, which is why we prefer the expression "conscious" suicide or "unconscious" suicide. Thus, conscious suicide is the act by which the insured takes his own life in full use of his faculties".

[85]JERRY/RICHMOND, *Insurance Law*, 5th ed., New Providence, 2011, p. 276 when they ask: "What constitutes an "interest" in a life?" to which they answer, as certainly every person has an interest in his own life, which does not mean that one has a pecuniary interest in one's own life. However, they also note that although this rule is so, it does not mean that it is to be applied in a "rigidly" way. BUTTARO,

intrinsic to life itself, to human beings, to have an unlimited interest in their own life, in living[86]. It is a different matter to be aware of this interest or what it means[87]. Or to put it another way, a presumption that is, in a certain sense, a genuine *fictio legis*, a legal fiction[88].

What the jurist of today must do is to cast off the old clichés and stale doctrinal pigeonholing that anchored the debate in unitary and dualist theories and where the pivotal point was the principle of indemnity, which led some to extend the indemnity nature and, therefore, to preserve the dogmatism of the unitary theory at all costs, to life insurance. And thus, incorrectly modulating the interest and the very notion of interest[89].

This interest is undoubtedly projected at the time of taking out an insurance policy, this interest is manifest in an implicit, unquestionable way in the insured policyholder, but

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L'interesse, cit., p. 227, affirms that also in life insurance there is an interest of the insured in the non-verification of the loss. The individual wants to protect his own interest in life.

[86]This does not imply denying certain theoretical difficulties that the doctrine has been clearing up. An example of this questioning can be found in the reflections of TAYLOR in the forties of the last century, "The law on insurable interest in North Carolina", cit., p. 255, when he pointed out: "The question of insurable interest in lives generally raises more problems than those found in relation to insurable interest in property. This is mainly due to the fact that life insurance involves problems peculiar only to this type of insurance contract and, in addition, includes those which are also characteristic of other types of insurance contracts. In general, life insurance is not insured for indemnity purposes, but as an investment. Occasionally, however, as when a creditor or a corporation applies the life of a debtor to the life of a valuable employee, the contract involves an indemnity and therefore, in this respect, the rules applicable to the insurable interest in property may properly be invoked. A consideration of the cases will show that much of the confusion that developed in relation to the determination of what constitutes an insurable interest in life was the result of this duality of life insurance purposes".

[87]The meaning of this interest for BUTTARO, *L'interesse*, cit., p. 227 is none other than that the existence of the interest means that the insured does not seek payment of compensation, but only protection. He points out, however, that the insurer's protection is not directly aimed at avoiding the damage, given that what the insurer seeks from the other party is only the compensation of the damage.

[88]This conceptualisation of legal fiction is coined by KEETON/WIDISS/FISCHER, *Insurance Law*, cit., p. 154 and for whom it is a means or way of articulating a proposition which essentially means that although generally the doctrine of insurable interest applies to life insurance contracts, any person - that is, anyone who does not have or suffers from a legal disability - can validly take out insurance on his own life in whatever amount an insurer is willing to write because it is impossible to assess the value of a life in economic terms.

[89]BUTTARO, *L'interesse*, cit., p. 253, was right when he pointed out: "In any case, whether one considers life itself as a good, or whether one prefers to think of it as a means of procuring what awaits us, it is necessary first of all to establish whether the loss causes a compensable damage".

above all in the bearer of the risk, the insured who ultimately decides to take his own life[90]. Is the insurance interest lost when the insured decides to commit suicide, and by this logic, would the contract be null and void for lack of supervening interest in the insured?

He insures his life, he insures his health, he insures any event or contingency that affects his life, even if what he is insuring is precisely his own death. But who insures and is interested in his own life, does he want to take his own life? What does he gain by doing so?[91]

Regardless of whether or not the figure of the beneficiary now appears, what happens if a potential beneficiary of a life insurance policy induces the insured to commit suicide, would we be dealing with a hypothesis of involuntary manslaughter on the part of the beneficiary, would he have an interest in the life of the insured and, in addition, having induced the latter to commit suicide, would he have dignity for the collection of the indemnity? The insured person's interest is in his own life, which does not preclude him from being interested in other persons and thinking, stipulating, and perfecting the insurance contract so that this other person or persons are the ultimate recipients of the sum insured.

[90]KEETON/WIDISS/FISCHER, *Insurance Law*, cit. p. 153, point out how it is often said that every person has an "unlimited insurable interest" in his own life. It does not escape the American professors how this meaning of insurable interest is conceptually speaking not easily reconcilable with the principle of indemnity, given that indemnity usually implies the existence of a quantifiable pecuniary interest.
[91]VIVANTE, *Del contrato de seguro*, Tomo 15, vol. II, Buenos Aires, 1952, p. 87 "If the suicide could enjoy his violent act, this sanction would be just and prudent. But those who claim the insured capital are, ordinarily, the orphans of the suicide. Now, is it more useful to social security that they inherit from their father, together with the tendency to suicide, the misery that drags them into the same predicament, or is it more useful that they come to bless their father for the sacrifice he made in insuring them, with the sacred foresight of their future? The opinions we combat are school opinions, which vanish before the tragedies of life; no judge would want to let the widow and the orphans die of despair in the name of a pretended public order".

But is there an interest or is it damaged if an insured person commits suicide? If the insured person is entitled to a life interest, does self-injury, his own death, eliminate this interest or not? In effect, the exegesis of Article 93 of the LCS allows the coverage of this contingency, just as it tolerates the exclusion. In a certain sense, the question is relegated to a political and commercial decision of the insurance company itself, which can include or exclude self-injury, or provoking one's own death. There is no doubt that the treatment of suicide has a direct impact on the delimitation of the risk related to the causes of death, just as homicide does[92].

It is obvious that the death of a person is either due to natural, fortuitous, endogenous, etc., or human causes. It is an attack against the interest, it breaks it. In this second area we are dealing with hypotheses of homicide if they are caused by third parties, but we are dealing with suicide when the death is caused, provoked, by the victim himself[93]. The Insurance Law, like practically no other comparative regulation, warns of or dualizes any provision when death is caused by natural causes.

Thus, the causal and logical consequence cannot be other than to deduce that in this hypothesis the indemnity is due whatever the cause of death, that is, a natural cause[94]. In the case of the homicide of the risk carrier, the insured, (also the holder of the insured interest, although it can also be a third party on whose head the risk and the insurance in

[92]As KEETON/WIDISS/FISCHER, cit., p. 411 rightly point out, suicide clauses included in life insurance policies often include the phrase "sane or insane", thus not allowing coverage for a given period in the policy, even if we were dealing with a suicide in which the suicidal person suffered from dementia. The authors warn that "Insanity may, however, be found to have negated suicide even when the "sane or insane" language is used in the policy".

[93]In *Atkinson v. Life Ins. Co.,* 228 S.E.2d 117, 120 (Va. 1976) stated:
"If the act of self-destruction would be regarded as suicide in the case of a sane person, it would be so treated as to an insane insured, regardless of whether the insured decedent realised or was capable of realising that such act would cause his death or whether he was capable of entertaining an intention to kill himself".

[94]ROSSETTI, *Il diritto delle assicurazioni*, vol. III, cit. p. 871, who adds that for death arising from the act of man or of the victim himself, which includes accidental ones, the law is concerned as well as the policy by establishing a series of guidelines.

sum hangs), it is always necessary to distinguish between the homicide of the insured or risk carrier caused by a third party, from that other homicide that has been provoked by the beneficiary, or even by the policyholder of the insurance contract.

The death caused by a third party to the contract or to the insurance relationship automatically generates compensation, whoever it may be, in accordance with the policy. On the other hand, the death caused by the beneficiary or by the policyholder does generate legal consequences within the legal insurance relationship according to the LCS but also according to the dictate of the policies themselves. But does the beneficiary not have an interest in the insurance in its compensatory dimension rather than an interest in the life of this third party?

The old insurance regulation contained in Article 423 of the Code of Commerce was, if possible, more forceful, stating that "insurance in the event of death shall not include death if it occurs by suicide". It is also worth noting the Supreme Court ruling of 9 January 1962, very much in line with French jurisprudence, which, in substance, came to establish:

> *"Suicide is to be understood as "voluntary" suicide. There is no involuntary suicide; there is suicide only when death is caused or occasioned by conscious acts of the agent. When there is a lack of will, due to disturbed mental faculties, suicide does not occur".*

The judgment then went into questions of voluntariness, adjectivizing this in different hypotheses, ranging from greater or lesser voluntariness, diminished voluntariness, the presumption of abnormality in the subject, etc., stating in its last recital that "there is no legal reason to exclude death due to such acts[95]. On the other hand, there is a reason for

[95]Along these lines, the Supreme Court ruling of 25 September 2007 (LA LEY 170696/2007) has special relevance in judging cases of suicide and the circumstances of each specific case. In other words, it does not respond to an act of voluntariness on the part of the worker, which can make it declarable as an accident

the precept to exclude death by suicide (which cannot be anything other than voluntary) from the insurance because, if this risk were covered, the random nature of the contract would disappear and fraud by the insured would be permitted"[96].

The natural insurability of suicide

Suicide is today both an insurable and an insured risk[97]. As is and can be its legal and conventional exclusion. An exclusion that may be total or subject to the passing of a certain period. Exclusion that, if there is one, must be clearly stated, and confirmed by the insurer[98]. Within the delimitation of the conventional risk, which is not legal, can the insurer not exclude death caused by voluntary or intentional suicide always and in any case? Or are we on the contrary faced with a genuine manifestation of a purely legal and non-conventional exclusion?[99] what happens when death occurs because of an overdose?

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at work, regardless of whether or not the suicidal act takes place in the workplace and/or during the working day. The injury and the accident are generated directly, not by the will of the suicidal employee - it is not the product of his or her conscious and free will - but as a consequence of an external cause that is alien to his or her intentionality".

[96]With regard to this judgement, VELLVÉ, "Lagunas en "lo legal" del seguro de vida español", RDP, 1967, pp. 940 and following, p. 941, pointed out that with this judgement it seems clear that the Supreme Court considers true suicide (that of the person who voluntarily takes his own life) to be uninsurable because such insurance goes against the random nature of the insurance contract and, what is more, would allow fraud by the insured.

[97]On the legal and doctrinal evolution of suicide insurance in France, see the contribution of KULLMANN, "Suicide et assurance: une déjà vieille notion, mais un tout nouveau régime", RGDA, 2002, pp. 907 et seq.; GROUTEL, "Le suicide en assurance sur la vie: une réforme inspirée", Resp. Civ. et Assur. 2002, pp. 2 et seq.

[98]However, some legal systems have been or are more permissive and require mandatory coverage of suicide from the first year of the insurance period. Thus, the conventional exclusion of suicide from the second year of the contract is not permitted in French law, whose Article L. 132-7 al 2 of the Insurance Code provides that "insurance in the event of death must cover the risk of suicide from the second year of the contract". Thus, as stated by LAMBERT-FAIVRE/LEVENEUR, *Droit des assurances*, 14th ed., Paris, 2017, p. 332, it is from the second subsequent year that this increased risk of suicide is imperatively covered by the supplementary guarantees.

[99]LAMBERT-FAIVRE/LEVENEUR, cit., p. 331, raise the legal exclusion of suicide to three conditions, but only during the first year of cover, taking into account that the French regime does oblige cover from the second year onwards. Firstly, the voluntary nature of the death, secondly, that the suicide takes place within the first year of the insurance cover and, thirdly, that the contract must be a death insurance contract other than a group insurance underwritten by a credit institution.

what if we were faced with a case of massive ingestion of drugs, opiates, etc., is there voluntariness? What would the insurer have to prove, accident or voluntary suicide? Shouldn't the insurer try to prove that the suicide was conscious, and voluntary, given that both are not presumed?

It constitutes a violent death which requires, on the other hand, a medico-legal confirmation[100]. As defined in Article L. 132-7 of the French Insurance Code, "the act of giving oneself death, a gift which cannot be voluntary"[101]. However, it is limited in time at least by the coverage of a minimum number of insurance periods, so it is not covered if the claim occurs in the first year of coverage [102].

To this should be added the exceptional nature of the freedom of autonomy of the parties, which, in a reciprocal manner, could admit the immediate insurance of suicide without

[100]In this sense, LAMBERT-FAIVRE/LEVENEUR, cit., p. 330 affirm that suicide constitutes a violent death that requires medical-legal confirmation. And even if suicide is not a crime, a medical, police and judicial study must prevent a homicide from being disguised as a suicide. So, if it does occur, it must be declared as the cause of death on a death certificate.

[101]For MAYAUX, "Le décès par suicide", Les assurances de personnes, tome 4, cit. p. 79 "le mobile qui le guide enlève à son acte tout carèctere intentionnel".

[102]LAMBERT-FAIVRE/LEVENEUR, cit., p. 330 define suicide as the action of voluntarily causing one's own death. The usual definition of suicide underlines the intentional act according to article L. 113-1 C. assur and "il n'y a pas suicide prouvé lorsque la volonté suicidaire n'est pas démontrée". Anecdotally, the French professors exemplify the death of the actress Marilyn Monroe due to the ingestion of barbiturates. They state that as this act does not in itself prove the will to commit suicide, the ingestion of an excessive quantity of sleeping pills can be an accidental mistake. The proof of a suicidal will is also difficult to separate in certain accidents of the "route" which seem technically inexplicable. See STIGLITZ, *Annotated Civil and Commercial Codes. Ley de contrato de seguro*, 2011, cit., p. 856, how the requirement of voluntariness excludes the hypothesis of the suicide of someone whose mental faculties are altered, since in this case insanity operates as a fortuitous and uncertain event and, therefore, insurable. Hence it is held that involuntary suicide, either because the agent is in a state of mental disturbance which has prevented him from appreciating the nature of the act and measuring its effects, or because its origin is due to a merely accidental event, to a fortuitous circumstance, completely foreign to a deliberate and conscious decision on his part, cannot fall under the rule of the legal precept which excludes it. And on p. 857 he points out how mental disorders occupy a prominent place, whether in the typical form of alienation or in other related states. Hence, somnambulism and hypnotism can be equated with madness proper, since the subjects who suffer from them are neuropathic and in their acts, due to the action of magnetic manoeuvres, act like automatons, with absolute absence of psychic faculties. Analogous is the situation arising from states of alcoholic drunkenness or from ingestion or aspiration of alkaloids, such as opium, cocaine, morphine or similar. In summary, when suicide is the result of a pathological state, it is equivalent to an act of God and is therefore guaranteed by the insurance relationship.

the need for the passage of any time threshold[103]. But at the same time, the total exclusion of the same throughout the life of the contractual relationship.

However, if we keep alive and valid the distinction between voluntary or involuntary, or if we prefer, conscious or unconscious, the latter would always be within the coverage of the risk, not exempt from evidentiary difficulties on the part of those who wish or try to assert their rights as beneficiaries. Are we facing terms that are both equivalent and necessary when speaking of voluntary and conscious giving oneself death? Are voluntariness and consciousness antithetical?[104]

Or, on the contrary, are they interdependent?[105] Is there a voluntary suicide if there is no awareness of it? Is there a suicide that is compulsorily guaranteed or covered and,

[103]This is a common practice nowadays and admitted in any legal system. In the Italian experience, Art. 1927 Codice exempts the insurer from payment of the indemnity if two alternative conditions occur, first, if the suicide occurs before two years have elapsed from the stipulation of the contract and, second, if the suicide occurs before two years have elapsed from the day on which the suspension of the contract ceased, verified ope legis ex art. 1924 Codice, due to non-payment of the premium. ROSSETTI, *Il diritto delle assicurazioni*, vol. III, cit. p. 872, analyses how the derogability of the first hypothesis is expressly foreseen in art. 1927 itself, but in the second case, the derogability is only recognised by way of Cassation interpretation, given that art. 1927 is not included among the norms expressly declared non-derogable by art. 1932 Codice. Thus, the Civil Cassation judgment of 17 July 1991, no. 7956, Foro it. Rep., 1991, no. 117.

[104]HALPERIN, Contract, cit., p. 526, critically and harshly stated that one cannot speak of a presumption of normality in the subject. The rule is just the reverse. An overwhelming proportion of suicides are mentally abnormal, either insane - in the ordinary sense - or suffering from a profound psychic disturbance.

[105]In terms of legislative variability and evolution, the French experience is an example. The French insurance law of 1930 did not require the assumption of the risk of suicide to be conscious, on the contrary, the law of 7 January 1981 enshrined that the insured was the one who voluntarily and "consciously" gave himself death. The law of 3 December 2001 deletes the adverb "consciously". This has led to the interpretation and postulation of two ways, which MAYAUX, "Le décès par suicide", Les assurances de personnes, tome 4, cit., p. 80, on the one hand, if the condition of consciousness or conscious is given a broader content and assimilated to the requirement of free will, incompatible with unbearable suffering or a fixed idea. On the other hand, if it simply means that the person must be conscious at the moment of his or her gesture, its disappearance has no practical effect. There is no will without consciousness of one's actions and therefore no voluntary suicide without conscious suicide.

conversely, is there a suicide that is compulsorily excluded? Is a conscious suicide more or less anti-random than an unconscious suicide?[106]

In the United States the debate focused, as we have anticipated above, on the meaning of "sane or insane", thus, the judgment of the Supreme Court of California, *Searly v. Allstate Life Ins. Co.* of 4 April 1985, states:

> "The Court of Appeal reasoned that an "insane" person could not commit suicide and that, therefore, the phrase "suicide, whether sane or insane" was ambiguous. The weight of authority, however, supports a contrary conclusion. The phrase "suicide, sane or insane", or its equivalent, has been used in life and accident insurance policies for almost 100 years. In Bigelow v. Berkshire Life Insurance Co. (1876) 93 U.S. 284 [23 L.Ed. 918], the plaintiff beneficiary sued on a life insurance policy which provided that it would be void if the insured died by suicide, "sane or insane". The Supreme Court stated: "The words of this stipulation, 'shall die by suicide (sane or insane)', must be given a reasonable construction".
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> In specifically addressing the question of the ambiguity of the phrase, the court stated: "Nothing can be clearer than that the words 'sane or insane' were introduced for the purpose of excluding from the operation of the policy any intended self-destruction, whether the insured be sane or insane.... In the popular sense, as well as the legal sense, suicide means, as we have seen, the

[106]KEETON/WIDISS/FISCHER, cit., p. 412 point out that in reality the courts are faced with a real dilemma "confronted in attempting to deal equitably with coverage disputes arising as a result of death by a self-destructive act when the insured was suffering from some type of mental illness". Courts have sometimes chosen to understand the addition of the words "sane or insane" in the restrictions on suicide coverage to mean that the insurer is not required to show that the deceased did or did not have any understanding of the act he was committing (by its moral or legal nature), that is, that the act the deceased was unable to appreciate was an act of suicide and whether it could be viewed as "morally wrong" or as an illegal action that does not preclude enforcement of the exception. A rich casuistic overview is provided by SHIPLEY, Annotation, "Insurance: Construction of "Sane or Insane" Provision of Suicide Exclusion", 9 A.L.R. 3d, 1966, pp. 1015 ff, p. 1032.

death of a person by his own voluntary act; this condition, based, as it is, on the construction of this language, informed the policyholder that, if he deliberately destroyed his own life, the insurer would be free from liability. It is not necessary to analyse the various stages of insanity in order to determine whether a state of circumstances could not arise which might defeat the condition.... For the purposes of this judgment, it is sufficient to say that the policy was declared void, if the insured was aware of the physical nature of his act, and his intention, thereby causing his death, even though, at the time, he was incapable of judging between right and wrong, and of understanding the moral consequences of what he was doing".

Other jurisdictions have held that a policy which does not insure against the risk of "suicide, whether sane or insane" means suicide by intentional self-destruction by an insane or sane person. (See, *Johnson v. Metropolitan Life Insurance Company* (3d Cir.1968) 404 F.2d 1202, 1204; *Strasberg v. Equitable Life Assur. Soc. Of US* (1952) 281 App.Div. 9 [117 NYS2d 236, 240] ["insane self-destruction"]; 9 Couch, Insurance (2d ed.1962) § 40:41, pp. 671-672.)

We therefore conclude that the phrase "suicide, sane or insane" should be interpreted to mean suicide committed by insane persons. Although the degree of understanding of the physical nature and consequences of the act was in doubt in the case before the court, we conclude that the Searle I court erred in upholding the ambiguous clause and in reasoning that insanity necessarily precludes the formation of the intent to commit suicide.

A proper interpretation of the clause is that it exempts the insurance company from liability only if the insured, whether sane or insane at the time, committed the act of self-destruction with suicidal intent. If suicidal intent is

negated by a determination that the insured did not understand the physical nature and consequences of the act, then the company may be held liable for the full amount of the policy".

However, is voluntary or real suicide insurable, as the Supreme Court expressively coined almost five decades ago, or, in other words, is it possible to speak of malicious action in the suicidal insured?[107] Let us not forget that in the face of involuntary suicide, the conscience of the person who voluntarily takes his own life is at stake. Or what about the need for help from a third party to die in the case of active euthanasia?[108]. *What about* the voluntariness of the act?[109] What about mental capacity?[110]. In fact, for us to be dealing

[107]VELLVÉ, "Lagunas en "lo legal", cit., pp. 940 ff, p. 941 an ethical and religious digression, when he states: "It is well known that, historically, life insurance has had great difficulties, and one of them was its collision - let us put it this way - with Providence, that is to say, with religious faith and the ethics of this faith... there will always remain - in an ethical and religious order - the contradiction that a person can insure his life in order to be able to take it away voluntarily. There is here a protected suicide, more or less facilitated. It is true that suicide is not a crime for the suicide, although it is a crime for the co-author or accomplice of the person who commits suicide".

[108]MAYAUX, "Le décès par suicide", *Les assurances de personnes*, tome 4, cit. p. 80, argues that in this case "there is no suicide in this death since it is attributable to a third party who would have to refuse the help that was demanded of him".

[109]STIGLITZ, "Suicidio voluntario", *cit.*, p. 220, is right when he states how the requirement of voluntariness excludes the hypothesis of suicide of a person whose mental faculties are altered, since in this case insanity operates as a fortuitous and uncertain event and, therefore, insurable. For SUMIEN, *Traité théorique et pratique des assurances terrestres*, 7th ed., Paris, 1957, p. 140, the question of knowing whether the suicide is conscious or unconscious is a question of fact to be decided by the judge on the merits. Unconscious suicide, or involuntary suicide, must be understood as an act performed by a person habitually or temporarily deprived of reason, or where the will is completely clouded by an irrational and irresistible impulse. On the contrary, conscious suicide is the voluntary and reflexive act of someone who, under the influence of serious concerns about his honour, his fortune, his health, prefers to take refuge in death rather than face an "épreuve" for which he does not feel the courage or the strength to succeed. DE GREGORIO/FANELLI, *Le assicurazione*, cit., p. 160, pointed out that a priori and ex art. 1900, the insurer cannot assume the risk of the insured's malice, so that the insurer should not pay any benefit in the case of death of the insured determined by suicide or attempted suicide, which are typically voluntary claims. However, taking into account the natural instinct of self-preservation that in almost all cases overrides the will to bring benefits to others through the insured person's own intentionally provoked death, our legal system allows the assumption of the risk of suicide, This is why the law requires that the payment of the sum is conditioned to the passing of two years from the date of the conclusion or reactivation of the contract, being a sufficient term to dilute the suicidal intention of the insured.

[110]On suicide and mental capacity, the aforementioned judgment, Searly v. Allstate Life Ins. Co. of 4 April 1985, which states in paragraph D: "... the court erred on the first appeal in concluding that insanity necessarily implies a lack of mental capacity to commit suicide. Mental capacity is relevant in determining

with suicide, the agent subject must have the will to cause his own death[111]. A person can cause their own death by mistake, by the accidental handling of a weapon, by the wrong intake of drugs, etc., but in no way was there any intention to cause or provoke their own death. In addition to the enormous evidential difficulty that falls on the insurer, especially when it denies or tries to prove the involuntary nature of the suicidal act. As the judgment of the Provincial Court of A Coruña of 12 January 2013 stated in its second ground, section III:

> *"... It is true that it is difficult to prove that a person has committed suicide, but the same or greater difficulty exists if it is necessary to prove a negative fact, such as that he has not committed suicide, when, as in this case, the death of a person occurs when he falls from the window of a house, which may be due to an accidental event or to a deliberate act of the victim himself.*

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whether the insured committed an act of self-destruction with suicidal intent. If the insured did not understand the physical nature and consequences of the act, whether he was sane or insane, then he did not intentionally commit suicide. Although the ultimate burden of proving suicidal intent by a preponderance of the evidence remains on the insurer, the beneficiary should be allowed to present evidence to negate suicidal intent.

[111]This is stated by CORRIAS, "Artt. 1927", *Commentario breve al diritto delle assicurazioni* [VOLPE PUTZOLU (Dir.)], Milano, 2010, pp. 149 et seq., p. 149, in trying to establish a notion of suicide relevant to article 1927 of the Codice, points out how cases in which the subject takes his own life by mistake, negligence or lack of skill (such as, for example, incautious handling of a weapon, accidental ingestion of a poisonous drug, etc.) do not constitute hypotheses of suicide. He points out how case law has specified that "suicide, being characterised by the consciousness and will of the agent to produce the event of death, does not fall within the concept of accident, which must be understood instead as an event produced by a fortuitous, violent and external cause", Milan Appeal of 3 January 1989 (Ass, 1990, II, no. 2, pp. 162 and ff. The author insists on emphasising how the states of passion and emotion of suicide are irrelevant and, consequently, even if the insured person has been induced to suicide by a serious psychic disturbance and has not in any way influenced his decision to make or obtain profit for third parties with the sum insured, the insurer will be released, if the suicide occurs within two years of the conclusion or its reactivation.
In Dennis v. Union Mut. Life Ins. Co. supra, 84 Cal.5th 570, distinguished between suicide and self-destruction. In Dennis, however, the excepted risk in the policy was death by "self-destruction" and although the court found that the insured had "committed suicide or self-destruction with a gun" while temporarily insane, the suggestion that the two terms are equivalent is mere dicta. Moreover, Allstate cites Black's Law Dictionary (4th ed., 1968, at p. 1602) and quotes the definition: "SUICIDE: self-destruction". The full definition, however, reads "self-destruction", the deliberate termination of one's own existence, while in possession and enjoyment of one's mental faculties.

> *Therefore, in each specific case, the circumstances of the case must be examined to decide whether they are sufficient to prove that the fall was voluntary. And, in this case, if the appealed judgement itself understands that, even though suicide cannot be ruled out, the evidence is not sufficient to conclude that Mr. Onésimo committed suicide, a conclusion with which this judge agrees, it can only be understood that the fall was not voluntary, which means that art. 100 of the LCS is applicable*"[112].

Suicide, sleepwalking, dementia, hypnotism, drugs.

It cannot be ignored, however, that most cases of suicide are the consequence of psychological, biological, or organic alterations or pathologies, which limit or even annul the intellectual capacity and understanding, curtailing freedom and personality[113]. Can a

[112]The judgement also states, firstly, that suicide and accident insurance are mutually exclusive concepts, as is clear from the content of article 100 of the aforementioned Law, which states: "Without prejudice to the delimitation of the risk that the parties make in the contract, an accident is understood to be the bodily injury that derives from a sudden, violent, external and unintentional cause of the insured, which produces temporary or permanent disability or death", an accident insurance policy, in which the death of the insured is included within the foreseen risk, as long as it is an accidental death, that is to say death that derives from a violent, sudden, external and unintentional cause of the insured person, as defined in Article 100 of the aforementioned Law of the Insurance Contract, it can never cover death due to suicide because this implies the intentional death of the person. The evidence - documents, the forensic report, the statement of the forensic expert herself at the hearing and the statement of one of the agents who drew up the technical report on the death of the insured - is not sufficient to conclude that Mr. Onésimo committed suicide. In fact, the only thing that is certain and proven is that the latter died when he fell from the house he lived in. It has not even been proven in documentary evidence that he suffered from a depressive disorder, as this is merely a mere reference made by the forensic expert, but without any documentary support, or any reference to the source of this knowledge. And in any case, even if Mr. Onésimo did indeed present a pathology of this nature, it cannot be derived from this single fact that self-harm had taken place, as this would be tantamount to stating that everyone who suffers from it commits suicide, and it is obvious that this is not the case, as in such a case, and even more so in the current economic situation, suicide would be of pandemic proportions. Therefore, death may well be due to autolysis, as well as to a mere accident.

[113]STIGLITZ, "Voluntary Suicide", cit., p. 220, takes a step further when he points out how mental disorders occupy a prominent place, whether in the form of typical alienation or other similar states. Analogous is the situation arising from states of alcoholic drunkenness or from ingestion or aspiration of alkaloids, such as opium, cocaine, morphine, etc. In short, when the suicide is the result of a pathological state, it is equivalent to an act of God and is therefore covered by the insurance relationship.

hypnotized person commit suicide?[114] , to what extent can we speak of will and consciousness in the case of hypnosis? What about a sleepwalker? If voluntary and conscious suicide is the voluntary act or action of causing one's own death, is it not a fully intentional act? A voluntary and conscious action, based on the freedom of decision of the subject who, with a deliberate will in his actions and effects, commits suicide.

The somnambulist, while still acting, is not volitionally aware of the entity or intensity of his actions. Suicide is a conscious and voluntarily self-inflicted death. Only in this supposition and proven by direct or indirect presumptions of the true extent of the intentionality of the subject, the same would be excluded from insurance coverage, whether the same is consummated *ex-ante* or *ex-post* of the waiting period. Whoever is under hypnosis or somnambulism is not the owner of the scope of his acts, he is not aware of what he is doing. Another question is how and by whom the hypnotized insured person has reached a state of hypnosis and whether a third party can provoke and not prevent the hypnotized insured person from committing suicide.

And involuntary, unconscious suicide, when the subject is not even capable of discerning the intentionality or the unlawfulness of his acts, the action of taking his own life, does fall under the aegis of the cover. It is not involuntary when the victim consciously and deliberately provokes it[115]. Yes, if he causes his death unintentionally, even if there is gross negligence. But what if it is consequently due to a mistake?

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[114]For STIGLITZ, cit., p. 220, somnambulism and hypnotism can be equated with madness properly speaking, since the subjects who suffer from them are neuropathic and in their actions, due to the action of magnetic manoeuvres, act like automatons, with an absolute absence of psychic faculties.

[115]Curious is the Supreme Court ruling of 21 July 2016, ruling 514/2016, in which the insured, one year and five days after taking out a life insurance policy, apparently due to the desperate economic situation of the family, took his own life. The policy provided for compensation to the beneficiaries, a wife and two children, of one and a half million euros. The insurer refused to pay on the grounds of fraud in the pre-contractual declaration of the risk, by leaving aside, firstly, the real economic situation of the insured policy holder and, secondly, certain family antecedents of death by suicide. TAPIA HERMIDA, "Suicidio y seguro: la Sentencia 514/2016, de 21 de julio, de la Sala Primera de lo Civil del Tribunal Supremo", [http://ajtapia.com/2016/09/suicidio-y-seguro-la-sentencia-5142016-de-21-de-julio-de-la-sala-primera-de-

For example, the wrong intake or higher doses of a medicine or a cleaning product, etc. Or an overdose of any opiate, drug, without at any time being the subject's intention to commit suicide, however, under a certain syndrome and need or anxiety to consume a certain drug, is a person fully aware of what they are doing? Or the case in which a worker decides to enter, play inside a machine without first or preventively deactivating it; or the one who takes a motorway in the opposite direction, at night and without lights[116]. What if, in the event of a fire, the insured person throws himself from a balcony or a window with little chance of surviving the impact?[117].

The judgments of the Gran Canaria Provincial Court of 21 December 2007 and the Valencia Provincial Court of 14 June 2005 also serve as a reference point. The sentence of 21-12-2007 of the Provincial Court of Las Palmas refers to a factual assumption consisting of a person jumping from a bridge in the presence of witnesses who tried to avoid it, in a person with a diagnosed and accredited mental illness and several previous suicide attempts... And the judgement of the Valencia Court of Appeal refers to a case of a person who had attempted a similar action on previous days, and who had jumped into the void on his own.

But what would happen in the latter case if such a person were under the influence of drugs, alcohol, etc., would this be an involuntary suicide? There is no doubt that the

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lo-civil-del-tribunal-supremo], comments on this ruling, placing special emphasis on both the evidential and expert question, and also points out: "When the red line of the first instinct of the human being is crossed, which is survival, any attempt at rational understanding collides with unreason. Suicide is therefore one of the most profound and complex problems that human beings can deal with and which presents, like a kaleidoscope, a multitude of facets that are always difficult to treat with the respect and attention that the case deserves. One of them, which is particularly relevant for the relatives who must try to understand what is very difficult to understand, is the patrimonial aspect and, within this, the insurance aspect".

[116]Two examples proposed by ROSSETTI, *Il diritto*, III, cit. p. 873 and which are not suicide. On the other hand, it is more difficult to decide whether or not it can be considered suicide in cases where there is doubt as to the capacity of understanding and will, as in the case of a drunkard who throws himself from a balcony into the void, not being able to understand the consequences of his own action.

[117]DONATI, *Trattato*, cit., p. 622, reminds us that in these cases the death thus involuntarily self-caused is not due to suicide but to misfortune, accident.

voluntary death caused to oneself by a person who is deprived of their capacity for understanding, comprehension, discernment, and will cannot have the same consequences as someone who is not. What about the suicide of an incapable person? Declared and established incapacity. Inimputable but also unconscious of the act he/she is carrying out, probably depending on the disability he/she may suffer.

Nullity or release of the insurer. The redemption of the premium

In many legal systems and traditions, suicide has been seen as the epitome of insurance fraud[118]. The act of taking one's own life has been seen as clear proof of insurance fraud, violating principles or axioms of the contract such as good faith and the uninsurability of fraud. In French insurance regulations, Article L 132-7 states that insurance in the event of death is null and void if the insured voluntarily commits suicide during the first year of the contract[119]. The insurance in case of death must cover the risk of suicide from the second year of the contract. But is committing suicide during this interim period or doing so voluntarily and intentionally really a case of contractual nullity?

If the cover is increased during the term of the contract, the risk of suicide, for the supplementary cover, is covered from the insurance year following this increase. The consequences are radical: nullity of the contract in the event of voluntary suicide, but nullity if it occurs within the first year of cover, not after that point.

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[118] In fact, as we pointed out in the first notes of this chapter of this book, referring to the work of VIVANTE, Il suicidio, cit., p. 4 ff, this was one of the main issues, fraud, il frode del contrato and la sacra buona fede.
[119]LAMBERT/LEVENEUR, *Droit*, cit., p. 314, remind us that the exclusion was originally two years until the law of 2 July 1998 reduced this exclusion to one year and "écartant" its application to group insurance taken out by credit institutions to guarantee reimbursement. They also note that freedom of contract makes it possible to exclude suicide from coverage in any case, although in practice this exclusion is not practised. They conclude that following the law of 3 December 2001 on the rights of the surviving spouse, the suicide guarantee now oscillates between interdiction and obligation. See the reflections of KULLMANN, "Suicide et assurance: une déjà vieille notion, mais un tout nouveau régime", RGDA, 2002, pp. 907 ff; also GROUTEL, "Le suicide en assurance sur la vie: une réforme inopinée", RCA, 2002, pp. 1 ff.

In Argentina, Article 135 of the insurance regulation states that the voluntary suicide of the person whose life is insured releases the insurer, unless the contract has been in force uninterruptedly for three years. Coverage is legally excluded for voluntary suicide, that which is imputable, that which the insured person decidedly wants and executes on himself, but only eliminates it from coverage during the first three years of validity of the insurance policy, so that from that moment onwards the insurer would cover it, nothing is said in the regulation about the coverage or not of involuntary suicide. However, the parties can agree on a waiting period of less than three years, or eliminate it.

In Italy, as we pointed out *above* when analysing the content and scope of Art. 1927 and its derogability provisions, the former in accordance with the law, the latter in accordance with the criteria of the Court of Cassation, in a significant judgement of 17 July 1991, no. 7956. The derogability clauses, like the inclusion clauses, certainly do not trace the liability of the insurer, but the express delimitation of the contractually assumed risk, or on the contrary, its exclusion[120] .

The insurer undoubtedly bears the burden of proof of the suicide during the waiting period as well as the burden of proof of the voluntariness of the act. But once the waiting period has elapsed, are we dealing with a sort of incontestability clause?[121]. It will have to be proved that the insured has committed suicide voluntarily during the waiting period and proving that the occurrence of the harmful event, suicide, took place under these premises. It is clear that the voluntary suicide of the person whose life is the object of the insured risk is an assumption of legal exclusion of the coverage.

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[120]ROSSETTI, *Il diritto*, III, cit., p. 872, is right when he points out, as a second consequence, that the suicide clause, apart from inclusion versus exclusion, does not determine any significant imbalance of the rights and obligations deriving from the contract, since the clause that prevents the obtaining of a benefit for a surprising human act of a life cannot be considered unbalanced.

[121]In the American doctrine, see the contribution of TINIO, "Suicide Clause of Life or Accident Insurance as Affected by Incontestable Clause", 37 A.L.R. 3d 337 (1971) where it is precisely whether or not the exclusion constitutes an incontestability clause.

He voluntarily and consciously causes his own death, as the epitome of a purely intentional act. But if suicide is taking one's own life voluntarily, it is not suicide but an accident, the case in which the subject takes his own life by mistake, inattention, negligence or inexperience, etc., as for example in those cases where there is an inexpert and imprudent handling of a firearm, when a poisonous food or liquid is accidentally ingested, etc[122].

Among the very few judgments handed down by the High Court on this issue is that of the Supreme Court, Civil Division, of 21 July 2016. In this case, the policyholder had taken out a life insurance policy in the event of death for 1.5 million euros in which the beneficiaries were his wife and children. The Supreme Court upheld the conviction of an *insurance company* to pay 1.5 million euros to a family for the life *insurance policy* taken out by the father a year before he committed suicide. The insurer alleged that the *policyholder* provided false and inaccurate information about his financial and property situation (which was worse than he claimed), and also failed to disclose that there was a history of suicide in his family, which would have prevented a correct assessment of the insured risk and relieved it of the obligation to pay. However, the Supreme Court rejected such arguments and endorsed the criteria of the Provincial Court of Madrid, which considered that the veracity of the data on his economic situation provided by the insured to the insurer before the subscription of the life *insurance* contract had not been distorted. Likewise, the Madrid Provincial Court ruled out that the insured had taken out the *insurance with the* aim of committing suicide one year later.

On the fourth ground it is stated:

> "... it is alleged that the policyholder provided absolutely false and inaccurate data on the true financial and asset situation, which are absolutely relevant for the correct assessment of the risk insured by Aegon. Such circumstances, had

[122]Thus, according to DE GREGORIO/FANELLI, *Le assicurazione*, cit. p. 161.

> they been known to Aegon, would have led to the policy not having been concluded. The conduct of the policyholder frustrated the purpose of the contract for the insurer by not providing it with all the information it knew and led the company to conclude a contract that it would not have concluded if it had been made aware of all the circumstances it knew. This fraudulent breach of the policyholder's duty of declaration releases him from the payment of the claimed benefit in accordance with Article 10 and Article 89 of the *Insurance* Contract Law.
>
> ... The plea is rejected on the ground that the appellant's argument is based on the assumption that the policyholder provided completely false and inaccurate information about its true financial situation, which the judgment under appeal does not find to be proven. While it is true that the appellant has challenged this by means of the extraordinary appeal for breach of procedure, it is also true that the latter has not been upheld and, therefore, that fact, the basis of the defendant's plea, is deemed not to have been proved'.

The death caused by a third party to the contract or to the insurance relationship automatically generates compensation, whoever it may be, under the policy. On the other hand, death caused by the beneficiary or by the policyholder does give rise to legal consequences within the legal insurance relationship according to the LCS, but also according to the policy itself.

But at the same time, the total exclusion of the same throughout the life of the contractual relationship[123]. This being so, the question regarding the time of admissibility of this risk must be focused on, following the dictate of Article 93 LCS, if there really exists a

[123]TAYLOR, *The law of insurance*, cit., p. 26, with a range from two years, to the prohibition in Missouri of excluding suicide as a risk "for any length of time whatsoever, the defence of suicide being available only upon a showing that the policy was secured incontemplation of suicide".

supposed period of *vacancy* where the insurer would not be insured or could freely cover this risk ab initio of the coverage. Another question is whether it is voluntary or intentional. But now it is of interest to clarify whether a temporary interim period of two years, one or none should be waited for to insure this risk[124].

However, if we keep alive and valid the distinction between voluntary or involuntary, or if preferred, conscious, or unconscious, the latter would always be within the coverage of the risk, not exempt from evidential difficulties on the part of those who wish or attempt to assert their rights as beneficiary[125]. In this way, as has been stated, when suicide is the result of a pathological state, it is equated to an act of God and, therefore, is guaranteed by the insurance relationship[126]. And conversely, there is no voluntary suicide without conscious suicide[127].

Are we dealing with terms that are both equivalent and necessary when speaking of voluntarily and consciously giving oneself death? Are voluntariness and consciousness antithetical or, on the contrary, interdependent?[128] Is there a voluntary suicide if there is

[124]In Belgian law, BINON, cit., p. 464, points out how the LCAT in its Article 101, then Article 164 of the LA, states that, unless otherwise provided, the insurer does not cover the suicide of the insured person occurring less than one year after the contract takes effect. However, the insurer is free to cover or not to cover the suicide during the first year after the contract has taken effect. And clarifies on p. 465 "le refus de couverture dont il peut faire l'objet pendant la première année de prise d'effet du contrat doit, selon nous, s'analyser comme une cause de déchéance, opposable au bénéficiaire en vertu des règles relatives à la stipulation pour autrui".

[125]BESSON, "Assurances", cit., p. 817 after stating how policies could extend the exclusion relating to suicide to both conscious and unconscious suicide: "Peuvent-elles inversement restreindre l'exclusion et spécialement garantir le suicide conscient?".

[126]Thus, STIGLITZ, *Annotated Civil and Commercial Codes*, cit. p. 857.

[127]On this point, MAYAUX, "Le décès par suicide", Les assurances de personnes, tome 4, cit. p. 80, who states categorically that there is no will without awareness of one's actions and therefore no voluntary suicide without conscious suicide.

[128]In terms of legislative variability and evolution, the French experience is an example. The French insurance law of 1930 did not require the assumption of the risk of suicide to be conscious; on the contrary, the law of 7 January 1981 enshrined that the insured was the one who voluntarily and "consciously" gave himself death. The law of 3 December 2001 deletes the adverb "consciously". This has led to the interpretation and postulation of two ways, which MAYAUX, "Le décès par suicide", Les assurances de personnes, tome 4, cit., p. 80, on the one hand, if the condition of consciousness or conscious is given a broader content and assimilated to the requirement of free will, incompatible with an unbearable suffering

no consciousness of it? Is there a suicide that is obligatorily guaranteed or covered and, conversely, is there a suicide that is obligatorily excluded? Is a conscious suicide more or less anti-random than an unconscious suicide? It is certainly not easy to reconcile consciousness and unconsciousness with randomness and therefore with what is uncertain and unforeseen and what is necessary or will happen.

Pathologically, those whose mental faculties are altered do not act from the profile and sieve of voluntariness, but from impulse, irrationality, and a certain obnubilation that deprives them of the conscious knowledge of the reality of what they are doing. This leads us to an area of uncertainty, of not knowing whether the actor will provoke his own sinister. Even in suicide, the area is present in some form.

However, today as yesterday, the same question remains valid and has already been raised in these pages, namely: is voluntary or real suicide insurable, as the Supreme Court expressively coined almost five decades ago, or, in other words, is it possible to speak of malicious intent in the case of the suicidal insured?[129]. Let us not forget that in the face of involuntary suicide, the conscience of the person who voluntarily takes his own life is at stake. Or what about the need for help from a third party to die in the case of active euthanasia?[130]

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or a fixed idea. On the other hand, if it simply means that the person must be conscious at the moment of his gesture, its disappearance has no practical effect.

[129]VELLVÉ, "Lagunas", cit., pp. 940 ff, p. 941 an ethical and religious digression, when he states: "It is well known that, historically, life insurance has had great difficulties, and one of them was its collision - let us say it this way - with Providence, that is to say, with religious faith and the ethics of this faith... there will always remain - in an ethical and religious order - the contradiction that a person can insure his life in order to be able to take it away voluntarily. There is here a protected suicide, more or less facilitated. It is true that suicide is not a crime for the suicide, although it is a crime for the co-author or accomplice of the person who commits suicide".

[130]MAYAUX, "Le décès par suicide", Les assurances de personnes, tome 4, cit. p. 80, argues that in this case "there is no suicide in this death since it is attributable to a third party who would have to refuse the help that was demanded of him".

But can someone take their own life by mistake, by negligence, what if the insured person ingests a substance by mistake or confusion that causes death? Think of cases of accidental ingestion of a drug for example, or lack of knowledge in the handling of a weapon. There is no will to commit suicide, to provoke death, it is not sought, intended, or wanted. But if the person handling the weapon is an expert hunter, a military or police officer...?

It cannot be ignored, however, that most cases of suicide are the consequence of psychological, biological, or organic alterations or pathologies, which limit or even annul the capacity for intellect and understanding, curtailing freedom and personality[131]. And if voluntary and conscious suicide is the voluntary act or action of causing one's own death, we are undoubtedly facing an intentional act. A voluntary and conscious act or action, based on the subject's freedom of decision as the seller of the consequences of the act, with a deliberate will in the act and its effects. Suicide is the conscious and voluntarily self-provoked death. As conscious is the answer given in the questionnaire by the insured person who concealed or was reticent in the face of suicide attempts and certain questions in this direction. Only in this case and proven by direct or indirect presumptions of the true extent of the intentionality of the subject, the same would be excluded from insurance coverage, whether it is consummated *ex-ante* or *ex-post* of the waiting period.

And involuntary, unconscious suicide, when the subject is not even capable of discerning the intentionality or unlawfulness of their acts, the action of taking their own life, does

[131]Professor STIGLITZ, "Voluntary Suicide", cit., p. 220, goes a step further when he points out how mental disorders occupy a prominent place, whether in the form of typical alienation or of other related states. Even somnambulism and hypnotism can be equated with madness proper, since the subjects suffering from them are neuropathic and in their actions, due to the action of magnetic manoeuvres, act like automatons, with absolute absence of psychic faculties. Analogous for the Argentinian author is also the situation arising from states of alcoholic drunkenness or by ingestion or aspiration of alkaloids, such as opium, cocaine, morphine or similar. In synthesis, when suicide is the result of a pathological state, it is equated to an act of God and, therefore, is guaranteed by the insurance relationship.

fall under the aegis of the cover. This is not the case when the victim consciously and deliberately provokes it.

The insurer undoubtedly bears the burden of proof of the suicide during the waiting period as well as the proof of the voluntariness of the act. He must prove that the insured has committed suicide voluntarily during the waiting period and that the occurrence of the harmful event, suicide, took place under these premises.

The judgment of the Supreme Court of 21 March 2007 states concerning proof of suicide:

> "... It was disputed at both instances whether the cause of death of Mr. Jose Pedro was caused by an accident or by a voluntary action of the victim -suicide-, the latter being excluded from the cover of the life and accident policies taken out by the O.N.C.E. with the defendant company and now appellant, Previasa. The judgement of the Provincial Court, after assessing the evidence, considered that the cause of Mr. Jose Pedro's fall from the window of his house had not been justified, and as a consequence that it was voluntary, which, it says, "should have been accredited by the defendant, as it constitutes a case of exclusion of the coverage of the life *insurance* policy in its second clause and of the accident *insurance* policy in its fifth clause" .....
>
> The fall was not voluntary but accidental, which he deduces from the following: a) from the statements contained in the attestation, from which "neither of the two alternatives can be presumed with sufficient clarity", since on the one hand it is stated that "it is known that he had recently become depressive and at the same time quite aggressive, it is believed that he may have thrown himself out of the window", and also that "there are rumours that his brother due to his condition as a drug addict and habitual offender may have intervened in some way", a question which he then dismisses, without

such statements having any evidential force whatsoever; b) the deceased was blind, and according to his family, he was not able to find his way around the house, being drunk on the night of the events, which "generates a doubt about what happened, without the cause being proven, nor the way in which it happened"; c) the medical history of Mr. Jose Pedro, contains an interesting note of interest. Jose Pedro, contains a note of interest in relation to the case. It states that "he was found in the middle of the road. A knocking noise had previously been heard. The injuries he presented are suggestive of a fall, although the family claims that the window of his room was closed. There is therefore some doubt as to whether he was run over or fell from a first floor. The patient is disorientated although at some point he states that he has thrown himself". The Court of First Instance did not consider this to be sufficient to declare that it was proven that D. Jose Pedro voluntarily threw himself from the window, as it also refers to his disorientation and, the doubt that this implies, says the Court, "makes it difficult to assess the statements made, which on the other hand have not been the subject of witness evidence to clarify their exact meaning and scope", and d) Finally, the medico-legal expert report carried out to determine this point has not been able to make an aetiological diagnosis of the injuries, which goes beyond establishing precipitation as the mechanism of production of the injuries.

... The claim claimed the fulfilment of the *insurance contract* because the death of the insured had occurred in a violent manner, while the appellant invokes the hypothesis of *suicide* as opposed to accident, and this is not accredited by the person who should have done so as an impeditive fact through any means of proof, taking into account the difficulty of accrediting the intentions of the deceased, but which the insurer assumes from the

moment it provides cover for situations in which suicide is contemplated and excluded....

FOURTH. The assessment of consciousness and voluntariness is a "questio facti", which belongs to the field of evidential assessment, and is a sovereign function of the court of first instance (STS 26 April 2000) and the fact that the Court's Judgment considers that the existence of suicide has not been accredited, has not been undermined by the formulation of the other two grounds, relating to the evidence of presumptions and judicial recognition".

It is clear that the voluntary suicide of the person whose life is the subject of the insured risk is a legal exclusion from cover[132]. He voluntarily and consciously causes his own death, as the epitome of a purely intentional act[133]. But if suicide is taking one's own life voluntarily, it is not suicide but an accident, the case in which the subject takes his own life by mistake, inattention, negligence, or inexperience, etc., as in those cases where there is inexpert and imprudent handling of a firearm, when a poisonous food or liquid is accidentally ingested, etc[134].

But what happens when the suicidal person is intoxicated with the sole purpose of taking his own life, does the hypothetical insurance exclusion clause apply in this sense?

[132]NOËL, "La notion d'accident", RGDA, 2004, no. 2, pp. 309 et seq., p. 317, argues the urgency of elaborating a simple and unique concept of suicide that breaks the old duality between voluntary or conscious and involuntary, characterised by the fact of wanting to kill oneself? The conscious act, which is always voluntary, must be distinguished from the intentional act.

[133]American doctrine and practice distinguishes the suicide exclusion clause, understood as the self-destruction of a healthy person, but not for an unhealthy person. Thus, says TAYLOR, *The law of insurance*, cit, p. 26 for the great majority of American courts, a person is insane, as the Supreme Court points out: "If the death is caused by the voluntary act of the assured, he knowing and intending that his death shall be the result of his act, but when his reasoning faculties are so far impaired that he is not able to understand the moral character, the general nature, consequences, and effect of the act he is about to commit, or when he is impelled thereto by an insane impulse, which he has not the power to resist, such death is not within the contemplation of the parties to the contract and the insurer is liable".

[134]Thus, according to DE GREGORIO/FANELLI, *Le assicurazione,* cit. p. 161.

Significant is the judgment of the Madrid Provincial Court of 14 October 2019 which, in its third ground states:

> "In relation to the exceptions regarding the exclusion of coverage alleged by the defendant, the insurance policies in dispute describe the exclusion under analysis in the following terms: "The claims that occur to the insured party due to his actions under the influence of alcoholic beverages, toxic drugs, narcotics or psychotropic substances not medically prescribed. To this effect, it is considered that the insured person was under the influence of alcoholic drinks when the degree of alcohol in the blood is higher than 0.50 grams per 1.000 cubic centimetres". The interpretation to be made of this clause for a case such as the one under study, where the main motive of the deceased's action was to take his own life, is the one offered by the plaintiff. The exclusion is designed, according to the transcribed terms, for cases where the accident occurs as a consequence of the state of drunkenness or alcohol or drug addiction, not when the cause is something else, such as the will of the deceased himself, as then the drunkenness, whatever its degree, is only a means to achieve the proposed purpose, which is to kill himself. And this is what happened in the case under study, since in view of the Guardia Civil's report, and in the absence of any intervention by a third party in the act of death, the only explanation is the presence of the plaintiff's husband next to the rails of the train (lying face down by the side of the track, according to the train driver), in a place with no nearby population, at the exit of a tunnel of the railway line and in a position where the run over was inevitable, because of his desire to commit suicide, which had already been shown to his relatives (this was testified to the Guardia Civil by the son of the deceased in the same place and on the same day as the events occurred, in a personal and emotional situation where it is not possible to deduce the cold will to make a statement

> intentionally structured and designed to avoid the exclusion of insurance coverage, and the twin brother of the deceased), even on the day of death a few hours before the accident, as the son stated at the police station, also alluding to objective and subjective causes inducing suicidal intent, such as the poor economic situation and his depressive state. Given this evidence, the fact that in the course of his actions he decided to get drunk is incidental and can be explained by the obvious and understandable need to facilitate the development of the violent act chosen to kill himself. Therefore, the claim is covered by the insurance policies taken out.

But what happens if the insured commits suicide within the grace period? Thus, the judgment of the Audiencia de Girona of 20 February 2014 states in its fourth and fifth grounds before an insurance policy that covered the risk of non-payment of the loan due to the death of the borrower:

> "In the policy signed by the husband, the cause for exclusion of payment included, among others, the *suicide* of the insured (folio 35), when the husband died by suicide, according to the autopsy report provided by the insurer (folios 77 and 78).
>
> FIFTH. Two consequences can be inferred from the above:
>
> (a) In the present case, the bank's lack of standing 'ad causam' vis-à-vis the appellant arises from the action itself (claim for damages), and from the claim, directly for itself, for compensation corresponding to all the capital paid by the appellant because it does not have the capital insured by her husband, because the plaintiff has the status of insured party in the policy, the beneficiary being the bank, and therefore is not the primary beneficiary of the insured capital, as appears to be deduced from her application and, therefore, she does not have standing to seek or demand, for herself, the delivery of the

insured capital in favour of her husband in its full amount. It is not requested that the insurer pays the beneficiary of the policy and lender the amount corresponding to the capital pending repayment at the date of the incident, invoking a legitimate title or interest that would allow such a claim to be made, but rather the effectiveness of her husband's policy is sought, although not directly requesting the delivery of the insured capital to him, but rather the expenses generated precisely by having continued with the payment of the mortgage instalments after her husband's death.

b) In any event, the cancellation of the appellant's policy and the conclusion of a new one, in which her husband appears as the policyholder and insured, were made at the request of the couple themselves, as can be seen from the signature of both of them on those new policies in 2009, without there being any record from that date until 2012, when the action in the appeal was brought, of any complaint either to the bank or to the insurer regarding the errors and impositions that she now complains of in her claim and appeal.

The non-payment was due to the death of the plaintiff/appellant's husband, eight months after he had signed, for the first time, a life *insurance* policy and such non-payment was covered, not only by the terms and conditions of the policy within the agreed limits, without the exclusion being a limiting clause but rather a delimiting clause of the contract itself, but also by art. 93 of the *Insurance* Contract Law where it is stated that: "*Unless otherwise agreed, the risk of suicide of the insured person will be covered after one year has elapsed from the moment of the conclusion of the contract. For these purposes, suicide is understood to be the death caused consciously and voluntarily by the insured person himself*".

And even if the suicide is not covered and the insurer, therefore, refuses to pay the compensation, would there be an eventual right of redemption by the heirs of the premiums paid throughout the duration of the insurance contract, whenever the same exceeds the waiting period? Does the malice and conscious intention of the insured suicide kill or displace the eventual right of the heirs or relatives to redeem part of the provisions? In our opinion, in those cases in which suicide is excluded and in which the right to compensation of beneficiaries or final recipients of the compensation does not arise, either because in any case the etiology of the suicide, however, it manifests itself, has been excluded, or because the intentionality of the insured in his self-inflicted suicide is demonstrated, however, the right to recover the premiums would exist not so much for the beneficiaries as for the heirs or persons close to them (which could indirectly include beneficiaries, but who would have legitimacy due to their condition as heirs), as in the case of the spouse in the case of a community of property, to recover, to redeem, to recover the premiums.

Homicide in life insurance policies

While we have analysed the problem and the relatively frequent occurrence of suicide in the field of life insurance cover, or in general in personal insurance, it is now time to refer, at least minimally, to homicide. We have also referred above to the question of euthanasia and orthotanasia.

As can be easily imagined, one of the questions that we must analyze in this section is related to the actions of the homicidal beneficiary and the unworthiness of the latter to be the ultimate recipient of the sum insured given that, with his actions, he has caused the death of the insured. But let us think of not very extreme but recurrent cases, a driver who drives recklessly and suffers an accident in which his spouse of whom he was the beneficiary dies. Let us remember that Article 76 of the L.C.S. recognizes the injured party or his heirs and why not the beneficiaries and their heirs, the direct action against

the insurer to demand the fulfilment of the obligation to compensate, without prejudice to the insurer's right to repeat against the insured person, if it is due to the malicious conduct of the latter, the damage or harm caused to a third party. When comparing the provisions of articles 19 and 76 of the L.C.S., one cannot but appreciate in an initial approach a certain disharmony and contradiction.

The question is whether the death of the insured person by homicide provided that it is not caused by the beneficiary of the indemnity, also prevents the payment of the insured sum to those who are beneficiaries of the insurance. This assumption has nothing to do with the immorality of the beneficiary causing the death of the insured person collecting or receiving the sum stipulated in the insurance policy.

The perpetrator, accomplice, instigator, or accessory to the murder of the insured, even if the murder is not carried out, should not receive the insured sum[135].

The question is to decide whether the death of the insured person by the policyholder, or the death of the insured person by the insured person himself, which would be or would be included in the previous section on suicide, is sufficient cause to exonerate the insurer from payment and therefore leave the beneficiaries of the deceased without benefits. The exoneration of the insurer's duty, if the policyholder provokes the death of the insured person by homicide, would end up being detrimental for the potential beneficiary, be it a designated person or the heirs of the deceased insured person.

[135]On this point, article 192 of the Portuguese insurance contract law is clear and forceful. However, POÇAS, "A problemática do homicidio nos seguros de vida", *Problemas e soluções de direito dos seguros*, Coimbra, 2019, pp. 201 and following, p. 214, points out some doubts in relation to this article when he states that this regulation accepts as a general rule, firstly, that the insurer is not obliged to pay the benefit in the event of a loss caused maliciously by the policyholder or the insured and, secondly, the beneficiary who has maliciously caused the damage does not have the right to the benefit. In this way, Article 192 would merely be a manifestation of Article 46.2.º. Thus, the fraudulent homicide in which the policy holder participates would exonerate the insurer from its benefit as the participation of the third party beneficiary would maintain the insurer obliged to pay the same, excluding the murderer from the benefit.

Another area that could be clarified, and here the non-insurability of wilful intent is always present, is whether the wilful act is truly excluded in this case. In effect, intentional homicide would in any case be uninsurable, and involuntary or culpable homicide would be insurable. That is to say, causing the death of a third party by a negligent action but not wanted or desired in any case.

This takes us directly to the field of the uninsurability of fraud or bad faith as predicated in Article 19 LCS for all insurance contracts. The STS (1st Chamber) of 1 October 1994 (RJ 1994, 74.ª) of 1 October 1994 (RJ 1994, 7440), establishes the uninsurability of bad faith, understood in a double aspect: "The consequence of this is that in its interpretation the most generalized doctrine limits the uninsurability of this "bad faith" not only in its subjective aspect (the conduct of the insured omitting any reference to the policyholder), but also in the objective aspect, by projecting this conduct on the originating cause of the loss instead of on the result (article 17.4)".

To insure intentional conduct would go against morality and public order, as was made clear in the STS (2nd Chamber) of 14 March 1991 (RJ 1991, 2139): "There is no doubt that the exceptions established in arts. 19 and 48 of the LCS respond to an essential requirement of the insurance contract. To insure claims caused by fraud or bad faith would be contrary to public order (vid. art. 1255 of the Civil Code)". The question inevitably involves trying to scrutinise the real scope that article 19 must, or should, have and the different readings that we could give to it. In effect, we must ask ourselves - although this is something that we already raised in the first volume of the first volume of this Treatise - whether Article 19 LCS refers only to the insured person and, therefore, the intentional acts of other persons, such as the policyholder or the beneficiary, would not release the insurers or, on the contrary, the reference to the insured person must be understood broadly. The doctrine has been inclined towards a literal interpretation of the precept, because when the law has wanted to refer to other subjects, it has done so, for example, in life or accident insurance, in which the beneficiary loses his right to the benefit when

he has fraudulently caused the death or accident of the insured person. This is also understood by the STS (1st Chamber) of 1st October 1994 (RJ 1994, 7440), which declares that bad faith, in its subjective aspect, is limited to the insured because the precept omits any reference to the policyholder.

In another order of things, it would be necessary to anchor or look for the anchorage of the exoneration of the insurer's duty to provide the benefit in the case of homicide, also murder, of the insured person. It would never be possible if there are designated beneficiaries who have nothing to do with the homicidal action, and yes in the supposition of the author of the homicide, instigator, accessory, etc., who is at the same time a beneficiary, apart from the fact that there can be other "innocent" beneficiaries at the same time. Extreme cases would undoubtedly be those in which the murderer is one of the spouses or one of the beneficiary's heirs and the play or not of accretions and marital dissolutions and quotas[136].

The question is whether this criminal or criminal offence is directly equivalent to a civil offence in such a way that this would be the consequence, a civil sanction of unworthiness or immorality which means that the policyholder, for example, who killed the insured can in no way, ex Article 84.3 and its supplementary rules in the absence of a beneficiary, collect or see the insured sum paid[137]. What is the extent of a hypothetical civil and

[136]On this point, POÇAS, cit., p. 227 points out the case of the murderer who happens to be the spouse of the designated beneficiary, and who would also have been favoured with a direct patrimonial accretion as a consequence of the matrimonial property and rights regime. For the author and esteemed Portuguese colleague, the solution would be to set aside the hypothesis of payment to the beneficiary spouse by integrating it directly into the common assets of the matrimonial property regime, recalling how Art. 1733.1.º of the CC declares as incommunicable assets the insurance policies due in favour of the person of each of the spouses, which, without doubt and despite the lack of terminological rigour, infers that it also affects the capital of life insurance policies. We would be dealing with a merely eventual or hypothetical benefit of the murderer, so that for these purposes, the murderer will hardly have the expectation of inheriting the value of the sum, which will depend on the cumulative verification of several conditions. Among them, that of surviving the designated beneficiary.

[137]CALDAS, "As formas e os limites jurídico-penais de ajuda à morte e a sua relevância face ao novo regime dos contratos de seguro", *As novas questões em torno da vida e da norte em Direito Penal: uma perspetiva integrada*, Coimbra, 2010, pp. 286 and following.

insurance reprobation in any case of a criminal offence such as murder or manslaughter of the insured?[138]

In our opinion the intentional homicide, but not the culpable homicide, of the policy holder deprives the latter as well as the homicidal beneficiary of the compensation or sum insured and only in the case of there being no other designated beneficiaries, even in the supposition of the designation according to the clause of the forced heirs, would the insurer finally not pay any sum, not even in the eventual case of the state being the heir in the last instance, saving many pitfalls. Certainly, our Article 92 of the LCS infers this "death caused by malice aforethought"[139].

Article 92 LCS regulates precisely the death caused maliciously by the beneficiary but not from a connotation of the criminal offence but from that of the prohibition, recte, deprivation of the right to the insurance benefit. It is the other person's conduct, not the beneficiary's own, that consciously and deliberately causes the death of the insured. The article only considers this result, not any other result than death.

However, the article does not consider, for example, what happens if the death is caused by the policyholder, who in many cases is or becomes a kind of residual legal beneficiary? Article 92 concludes its provision that although the beneficiary causing the claim is deprived, the compensation is not deprived, which does not become the insurer's, unless nobody claims it, and it does stipulate that it is integrated into the policyholder's patrimony. But if the latter causes the claim, it is obvious that he does not have the right to the benefit either[140]. Therefore, the insurer is not exonerated from making the due

[138]There is no doubt in POÇAS, "A problemática do homicidio nos seguros de vida", cit., p. 215 when talking about this civil reprobation and the right to the homicidal crime. For the author, in the case of homicide, the regime of indignity of succession arises in the case of the conviction as author or accomplice of an intentional homicide, even if it has not been finally consummated.
[139]Among others, our commentary, VEIGA, Comentarios prácticos a la ley de contrato de seguro, Cizur Menor, 2020.
[140]TIRADO SUÁREZ, "Artículo 92", Ley, 4th edition, p. 2453.

benefit. Another question is that nobody claims it or there are no other beneficiaries, or they have allowed the limitation periods to elapse.

The doctrine has studied the hypothesis of undue payment, that is to say, the insurer who has unduly paid the homicidal beneficiary. In effect, when he paid the insured sum he was unaware of this, as there was not even a suspicion of homicide in the death of the insured. As can be easily imagined, the payment would be null and void, a null act, taking into account, although a posteriori, the unworthiness, and immorality of the beneficiary who, having provoked or caused the death of the insured, would collect the insured sum[141]. It is also necessary to consider whether or not in these cases of death of the insured person due to the homicide of the policyholder or of a beneficiary or even of a third party, a possible right of subrogation against the murderer on the part of the insurer who paid or complied with his benefit[142].

A false duality, homicide v. euthanasia.

There is no doubt that both homicide and euthanasia fully affect either the risk or the interest of the insurance contract. Both situations alter a priori the randomness of the insurance contract, in more than a few cases, with intentionality or voluntariness. From the premeditated to the declaration of the insured person who, having reached a certain vital situation, leaves his will or living will. But what happens in these cases with life insurance policies, whether their own or on third parties?[143] Does the insurance cover

[141]Thus, POÇAS, loc. ult. cit., p. 223 affirms that being the payment a null act, the regime of articles 286 and 289 of the Civil Code would be followed and not that of the repetition of what is undue in the case of unjust enrichment without cause.
[142]In favour of the same POÇAS, cit., p. 223, especially taking into account that in the field of insurance, the right of subrogation of the insurer in the average of the amount of what he has paid would be subrogated in the rights of the insured against the third party responsible for the loss. This rule is a sort of corollary of the indemnity principle.
[143]POÇAS, "A problemática do homicidio nos seguros de vida", *Problemas e soluções dos seguros*, Coimbra, 2019, pp. 201 and following, deals with this problem, with a historical retrospective of insurance.

euthanasia, or why, if the insured person is already deprived of knowledge but with a living will, did he or she express the admissibility and intention to have it applied to him or her? Another question is whether euthanasia is permitted or not in one regulation and whether it is covered by insurance in accordance with this legal admission or, on the contrary, whether nothing is regulated or even prohibited. Does insurance cover euthanasic death today? Is death by euthanasia comparable to death by suicide, or is it the same for animals?[144] What about palliative care cover for the terminally ill? It should be borne in mind that insurance policies do not exclude palliative care, so a sensu contrario, palliative care is or has been covered.

As is well known, in recent months the debate on the legality or otherwise of euthanasia has been raging. Spain in March 2021 [Organic Law 3/2021, of 24 March, on the regulation of euthanasia], has approved the regulation of euthanasia and assisted suicide, joining countries such as Holland, Belgium, Luxembourg and Canada in this regulation. To request it, the affected person must "suffer from a serious and incurable illness or a serious, chronic and incapacitating condition" that causes "intolerable suffering". Although it has been removed from the title of the law, the regulation governs both euthanasia itself - "the direct administration of a substance to a patient by a competent health professional" - and medically assisted suicide - "the prescription or supply to a patient by a health professional of a substance, in such a way that the patient may self-administer it, to cause the patient's own death". It cannot be ignored that, although the regulation on euthanasia comes into force in June 2021, three months of vacatio, the fact

[144]Already in 2007, Professor TIRADO, "Eutanasia y seguros de personas", said: "In the Spanish insurance practice of animal insurance, whether they are pets (dogs, cats, etc.) or animals dedicated to sport (horses, etc.), the insurance cover for euthanasia, understood as the destruction of the insured object, is contemplated, and it should be stressed that, for equines, the written authorisation of the insurer is required, with the aim of destroying the insured object.), the insurance coverage of euthanasia is contemplated, understood as the destruction of the insured object, and it should be underlined that, for the practice of euthanasia on equines, the written authorisation of the insurer is required, with the aim of confirming that it is produced by the irreversible physical state of the equine and not for economic reasons, derived from the disappearance of the economic-social function that the specific animal had, which ranges from sporting activity to leisure, including transport and loading".

is that, until now, a kind of passive euthanasia was not punishable in Spain, regulated by the Law on Patient Autonomy and Rights and Obligations regarding Clinical Information and Documentation, which establishes that the patient has the right "to decide freely, after receiving adequate information, between the available clinical options", as well as to "refuse treatment, except in the cases determined by law".

Belgium has provided for euthanasia since 2002 and since 2014, also for minors. Furthermore, it provides for two ways of euthanasia: for conscious patients and for unconscious patients. In the first case, it is essential that the euthanasia applicant meets the following requirements: that they are of legal age or a minor with parental consent; that the request has been made voluntarily, informed and repeatedly; that their medical situation does not foresee any improvement; that they have been informed of their options; and that the doctor who is going to perform the euthanasia has consulted another specialist.

For non-terminally ill patients, the doctor must also ask for a second opinion and the period of reflection between the patient's request and the act of euthanasia must be longer than one month. In the second case, for non-conscious patients, the patient must be an adult or have been declared to have adult status; the patient must be in an irreversible medical situation, either due to illness or accident; and the doctor must have consulted another specialist. In another neighbouring country, Luxembourg, legislation has also allowed euthanasia and assisted suicide since 2009, provided that the following conditions are met: being conscious at the time of the request; not having been declared incapacitated to make decisions; having made the decision without external pressure; being in a medical situation with no prospect of improvement caused by an accident or illness; and suffering from this physical or psychological situation in a constant and unbearable way.

The preamble of the new Spanish regulation of March 2021 itself states:

"Euthanasia etymologically means "good death" and can be defined as the deliberate act of ending the life of a person, produced by the express will of the person himself and with the aim of avoiding suffering. In our bioethical and criminal doctrines there is now broad agreement in limiting the use of the term "euthanasia" to that which is produced actively and directly, so that actions by omission which were designated as passive euthanasia (non-adoption of life-prolonging treatments and the interruption of those already established in accordance with the lex artis), or those which could be considered as indirect active euthanasia (use of drugs or therapeutic means which alleviate physical or psychological suffering although they accelerate the patient's death - palliative care) have been excluded from the bioethical and criminal law concept of euthanasia.

The debate on euthanasia, from the point of view of both bioethics and the law, has gained ground in our country and in neighbouring countries over the last few decades, not only in academic circles but also in society, a debate that is periodically rekindled as a result of personal cases that stir up public opinion. A debate in which different causes converge, such as the increasing lengthening of life expectancy, with the consequent delay in the age of death, in conditions that are not infrequently of significant physical and psychological deterioration; the increase in technical means capable of sustaining people's lives for a prolonged period of time, without achieving a cure or a significant improvement in the quality of life; the secularisation of life and social awareness and of people's values; or the recognition of the autonomy of the person also in the field of health, among other factors. And it is precisely the legislator's obligation to attend to the demands and values of society, preserving and respecting its rights and adapting the rules that order and organise our coexistence to this end.

...

It is not enough simply to decriminalise conduct that involves some form of aiding another person's death, even if it is at that person's express wish. Such a legal amendment would leave people unprotected with respect to their right to life, which our constitutional framework requires to be protected. Instead, the aim is to legislate to respect the autonomy and will to end the life of those who are in a situation of serious, chronic and incapacitating suffering or serious and incurable illness, suffering unbearable suffering that cannot be alleviated in conditions that they consider acceptable, what we call a euthanasic context. To this end, this Law regulates and decriminalises euthanasia in certain clearly defined cases, subject to sufficient guarantees that safeguard absolute freedom of decision, ruling out external pressure of any kind.

...

The euthanasia context, in which it is legally accepted to provide assistance in dying to another person, must be delimited according to certain conditions affecting the physical situation of the person with the resulting physical or mental suffering in which he or she finds himself or herself, the possibilities of intervention to alleviate his or her suffering, and the moral convictions of the person about the preservation of his or her life in conditions which he or she considers incompatible with his or her personal dignity. Likewise, guarantees must be established so that the decision to end life takes place with absolute freedom, autonomy and knowledge, thus protected from pressures of all kinds that could come from unfavourable social, economic or family environments, or even from hasty decisions. This euthanasia context, thus delimited, requires a qualified and external assessment of the persons

requesting and carrying out the euthanasia act, before and after the euthanasia act. At the same time, through the possibility of conscientious objection, legal certainty and respect for the freedom of conscience of the healthcare personnel called upon to collaborate in the act of medical aid in dying is guaranteed, understanding the term medical implicit in the Law when it speaks of aid in dying, and understood in a generic sense that includes the set of services and assistance that healthcare personnel must provide, within the scope of their competence, to patients who request the necessary aid in dying".

Although we have already alluded to the voluntarism or otherwise of suicide as the conduct sought by the insured person who causes his or her own self-induced suicide, article 4 of the euthanasia regulation is based on the right of the patient, the potential insured person, to request the provision of assistance in dying, indicating that the decision to request the provision of assistance in dying *must be an autonomous decision, understood as one that is based on knowledge of the medical process, after having been adequately informed by the responsible health care team.* The medical record must show that the information has been received and understood by the patient.

And among the various requirements established in article five, and perhaps at the very heart of euthanasia, is that of *suffering a serious and incurable illness or a serious, chronic and disabling condition under* the terms established in this Law, certified by the responsible doctor, as well as giving informed consent prior to receiving the aid in dying. This consent shall be included in the patient's medical record.

Perhaps one of the most relevant questions that has been asked so far about euthanasia was whether or not euthanasia, or the practice of euthanasia, could be assimilated to

suicide[145]. As well as to elucidate, at least until the legal admission of euthanasia, the role that a potential beneficiary of the life insurance of the insured person requesting assistance in dying could play in euthanasia. Although the perspective of analysis is dual, that of the beneficiary who helps the insured to take his own life and that of the beneficiary who, although assuming a passive position, or even of absolute ignorance of the insured's intention to take his own life, may suffer the consequences of such an event for insurance purposes and the non-coverage or classification of the event as a covered claim[146].

[145]Thus, TIRADO, "Eutanasia y Seguro de Personas", cit, electronic resource, said: "Now, the question arises as to whether euthanasia can be considered a suicide when it is not voluntary, a possible hypothesis, in view of the definition of the Royal Spanish Academy, and given that Article 93 of the Insurance Contract Law itself establishes a legal concept of suicide as "death caused consciously and voluntarily by the insured himself", it can be considered that if there is no express and specific consent for the act of euthanasia on the part of the insured person, it cannot be considered as a suicide for the effects of the aforementioned article 93, as the hypothesis would be analogous to homicide or any of its qualified variants, and therefore there would be insurance coverage in any case".

[146]The legislator would deprive the beneficiary, who has directly or indirectly promoted the euthanasia of the insured, of the right to receive the sum insured in the life insurance policy. In the event that the beneficiary is also the policyholder, the ratio legis means that, in this case, he/she would not have the right to the benefit provided by the legislator, since the legally envisaged patrimonial sanction would be violated, with the sum insured remaining in the hands of the insurance company as compensation for the nullity of the contractual link".

III. Reinsurance as a human right

Christina S. Ho
Rutgers University

The policy implications of my conference participation start from overall support for the broad view of sustainable development that centers on milestones of health and well-being instead of GDP or per capita income metrics. In focusing on the role of insurance in sustainable development, it follows that insurance regulation and operations should attend to a similarly broad set of values—not just individual financial security but security across a broader range of collective material stakes.

This starting point has several implications for other important debates in the development discourse. One implication is that human rights and individual entitlements can be if thoughtfully crafted, pursued in such a way that they also foster the systemic infrastructure and collective conditions for development

Examples of how insurance, and the native logic of insurance, can lend themselves to the reconciliation of individual claims and sound collective infrastructure emerge from certain counterexamples. During China's health reform in the early aughts, the government should have fostered more risk pooling rather than individual medical savings accounts and lists of essential drugs. Colombia in the last 1990's and early aughts, should have vigorously regulated private health coverage plans to enforce the provision of the promised benefit basket, heading off the flood of constitutional litigation against the government for health care that was denied under the national health system.

Finally, I note one promising area for insurance to interface with Member States' role in sustainable development, namely state-sponsored health reinsurance, examples include:

- Thailand's Central Fund and Health Intervention and Technology Assessment Program.
- China's Critical Illness Insurance
- Philippines, Z Benefits
- Uganda, DFID-funded government reinsurance of the Kisizi Hospital health insurance scheme
- And even in the U.S., through programs like Medicare and Medicaid which are tantamount to government absorption of the highest-risk populations including the elderly and people with disabilities.

Nowadays, any society, no matter how high-income, that lacks the infrastructure for managing catastrophic health disasters and covariant risk, is developmentally challenged.

IV. The adoption of measures to combat exclusion in health care provision by the insurance industry: combatting exclusion on the grounds of old age. Policy Recommendations

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Student at UNL

Mariana Cardoso
Student at UNL

Specific insurance schemes for seniors

Our first recommendation would be to create – or properly tailor – specific insurance schemes for seniors, a proposal which is heavily based on what the Madrid International Plan of Action on Ageing (MIPAA) prescribes in Paragraph 74, item b), and by McKinsey & Company's approach, which has been thoroughly cited on the original paper, for how realistic and up to date it is.

These schemes must be adapted to each person according to their age, economic capacity, personal autonomy, and self-awareness of the need for protection. According to McKinsey's approach, such a product needs to consist of five key points: protection, assistance, financing and liquidity management, investment, and well-being.

Community-based health insurance (EU health fund)

The second solution we proposed in the paper is the implementation of a European Health Fund, which would consist of a way of guaranteeing that all European citizens have access to proper healthcare conditions. To achieve this, every citizen, during their active period, would discount a monthly amount to this fund, which would be freely stipulated by each member state.

The World Health Organization (WHO) already recognizes community-based health insurance as a potentially affordable way to battle the challenge of providing health care for the most vulnerable in developing countries without worsening their situation. Even though the countries of the European Union are developed, it is undeniable that there are still disparities in the population's access to health care.

Presentations: Some Policy Recommendations

The Access of People Living with Preexisting Medical Conditions to Private Health Insurance in Spain: Recent Developments with Special Focus on the Point of View of the Regulator

María del Val Bolívar Oñoro

Contratada Posdoctoral del Programa Propio UAH

Content

The Ombudsman voice in the late 90's and 2000's

The 1999 Annual Report of the Institution reflects a complaint derived from the refusal of an insurance company to offer health care insurance to a minor because she had Hepatitis B.

After consulting the regulator, the Spanish Ombudsmen considers that insurance companies should offer a price if they have the capacity to make the calculations

The associations and the Convention on the Rights of Persons with Disabilities

- CERMI
- ONCE
- Barcelona Town Council
- CESIDA
- etc

Content

The amendment to introduce the DA 4ª in the Insurance Contract Law

Triggered by article 25 e) of the Convention on the Rights of persons with disabilities

It has not solved the issue, persons with disabilities still face barriers to access insurance due to their health condition

Agreement UNESPA-CERMI

The amendment to introduce the amendment to article 11 of the Insurance Contract Law

Personal Insurance: people is not compeled to comunícate changes in health status

Triggered by case law

Content

The amendment to introduce the DA 5ª in the Insurance Contract Law

Twin of the 4th

Same issue

The amendment to introduce the right to oncological oblivion (June 2023)

Radically different to the former ammendments

Triggered by the EU

Issues with the lenguaje, it is vage and wide

Content

The position of the Directorate General of Insurance and Pension Funds through the Ombudsman.

Insurance companies are free to conduct their businesses

The Spanish Ombudmen informs that they are, but they should bear in mind the legislation regarding equality and non-discrimination

Policy Recommendations

Insurance companies, the third sector and the State should work together to achive coverage for all. Otherwise certain groups will not have access to healthcare –students, persons seeking a residence permit, etc-.

“

Thank you

COVID-19 AND INSURANCE: THE IMPACT IN EUROPE

Prof. Dra. María Luisa Muñoz Paredes

University of Oviedo (Spain)

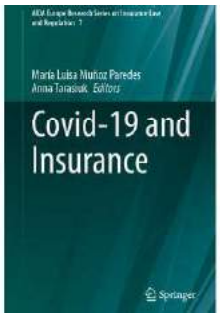
AIDA EUROPE

- AIDA Europe is a regional grouping of AIDA World (seat in Zurich) https://aidainsurance.org/regional-groupings/aida-europe
- AIDA (World)= *Association Internationale de Droit des Assurances* (International Insurance Law Association)
- AIDA World is a non-profit making international association, formed in 1960, to promote and develop at an international level the study of international and national insurance law
- AIDA Europe has the same aim: to promote the development of insurance law, but specifically at a European level
- To achieve its aim, AIDA Europe organises activities. Two of the most relevant are:
  - (i) International conferences:
    - with participants from all over the world, not only from academic sector, but also from the insurance industry and insurance lawyers
    - usually held every two years. The last one was held in Zurich in October 2022
  - (ii) insurance law book publications:
    - it has an agreement with one of the world's leading publishers, Springer. As a result of this agreement, a special series has been created, the so-called AIDA Europe Research Series on Insurance Law and Regulation

The AIDA Europe Research Series on Insurance Law and Regulation

- https://www.springer.com/series/16331
- The first book series of its kind and area of specialization
- It comprises volumes on topics researched and written with an international, comparative or European perspective
- It has now reached a total of 8 volumes in 4 years

The AIDA Europe Research Series on Insurance Law and Regulation, vol. 7



- Comprehensive study on the impact of the Covid-19 pandemic on private insurance from an international point of view

Increase of digitalisation

- The pandemic boosted the digitalisation of the insurance sector
- The increase in innovations are found throughout the product life cycle
- The most digitalised stages are sales and distribution (EIOPA, CTR 2021).

Increase of digitalisation

- Digital underwriting has advantages:
  - Fast
  - More attractive
  - It brings insurance closer to young people, who are used to taking out everything via their smartphones
  - It allows insurance to be taken out in developing countries in a very simple way, using just a smartphone or via web

Increase of digitalisation

- But, it has drawbacks:
  - The level of information received by the parties before contracting may be reduced, especially by the policyholder
  - The regulation applicable to the contract in terms of information may be thinking only of traditional contracting, leaving the consumer policyholder more defenceless
  - Lack of digital literacy or lack of digital devices can leave some certain sectors of the population (the most vulnerable) unable to access certain more economical insurance

Increase of digitalisation –EIOPA'S VIEW

- Digging deeper, EIOPA's first conclusions (*Consumer Trends Report*, 2021, published in early 2022) on the use and challenges of digitalisation in insurance are quite revealing:
- (i) Sales through e-channels increased significantly since 2018, but more in non-life business than in life-business
- (ii) Digital transformation also impacted pricing and underwriting with undertakings allowing consumers to use digital platforms to personalise their products whilst also increasingly using price optimisation practices;
- (iii) Greater use of price optimization practices which can lead to unfair treatment and possible financial exclusion of consumers
- (iv) While the risk of digital exclusion should not be under-estimated, most consumers surveyed by EIOPA as part of its consumer research, stated they prefer and appreciate digital tools which allow them to have on-demand engagement with their intermediary and their insurer

Increase of digitalisation –EIOPA'S VIEW

- (v) The new role preventative instead of protective of the insurance
- (vii) Increased evidence of cyber attacks
- (viii) A lack of clarity in terms and conditions and limited consumer understanding of exclusions can be detrimental for consumers.
- (ix) The lack of transparency and clarity is specifically worrying in relation to unit-linked products due to their complexity
- (x) The growth in uninsurable risks widens protection gaps
- (xi) More and more products being marketed as 'sustainable' raise concerns over the potential for so-called 'greenwashing'

Cyberrisk

- The increased digitalisation has brought with it an increase in cyber risks, which is one of EIOPA's major concerns (Financial Stability Reports of 2022, p. 7; and 2023, p. 4)
- Reasons of the increase:
  - Russia's invasion of Ukraine
  - Plus an already higher vulnerability of the sector during the Covid-19 pandemic due to an increased reliance on remote work and on digital solutions and infrastructure (June 2022 Financial Stability Report, pp. 23-24).
- Despite this, 69% of SMEs do not have cyber risk coverage and 15% of them do not even know if they have it or not (Consumer Trends Report 2022 of EIOPA)
- At the same time, the increase in cyber risks can be seen as an opportunity for the insurance industry, as it increases the need for cyber insurance.
- But the increase in attacks on all types of public and private institutions in the last year has led some insurers (like Zurich) to announce that they will no longer cover cyber-risks. However, there are insurers, such as AXA, that continue to offer cyber risk insurance specifically for SMEs.
- European Central Bank (January 2023): attacks on banks has tripled and private institutions will not be able to cope with these risks alone.
- The solution is also beyond the capacity of national governments. The effects are growing and have no borders. The Italian National Cybersecurity Agency (ACN) reported on 5 February a massive cyber-attack that had affected thousands of computer servers in dozens of countries, including the United States, Finland, France and Canada.
- The solution can only be as global as the attacks themselves

Effects on lines of insurance-Travel

- Travel insurance was one of the lines of insurance where the effects of the crisis could first be seen.
- As a result of the lockdowns, border closures and other measures adopted to contain the virus, many trips were cancelled before their date of departure.
- This prior cancellation caused the risk covered to disappear totally or partially. Consequently the contract became null and void and the insurer should have returned the premium not used because of the impossibility of performance of the contract.
- However (see EIOPA´S Consumer Trends Report of 2020), in practice many insurers did not refund the premiums, what made it necessary, in many cases, the courts intervention to solve the situation.
- In fact, in 2020 EIOPA observed a significant increase in claims ratios for travel insurance.
- In this situation, many insurers introduced exclusions to certain products or withdrew such products from the market, widening protection gaps.
- Consumers search travel insurance products because (i) of their desire to be more protected; in other cases, (ii) of the rising number of countries that were mandating travel insurance with specific travel medical insurance with COVID-19 coverage for international travellers.
- As a result of all this, new products offering COVID-19 coverage have emerged

Effects on lines of insurance-Travel

- What does coronavirus travel insurance cover? COVID-19 travel insurance cover can provide:
- (i) Cancellation cover before you set off
  - Travel insurance that covers COVID-19 can protect you for forced cancellation. For example, if:
    - You have coronavirus within 14 days of setting off (but you'll need medical evidence to be able to claim)
    - You're denied boarding a plane because you show symptoms
    - One of your travelling companions or close relatives fall ill with COVID.
- (ii) Cover while you're away
  - With COVID-19 travel insurance, you may be able to claim:
    - If you become ill or have a medical emergency
    - For being brought back home – with a medical companion, if needed
    - For accommodation or travel expenses if you have to extend your stay because of illness or a positive test
    - If you have to cut short your holiday – for example, if a close family member is hospitalised or dies from coronavirus while you're away
    - For unused, non-refundable, pre-booked excursion costs where you have to self-isolate due to contracting COVID-19.
- Source: https://www.comparethemarket.com/travel-insurance/content/corona-virus/

Effects on lines of insurance-Business Interruption

- Something similar to travel insurance in terms of claims, but more acute, can be seen on Business Interruption
- The miscellaneous financial loss line of business which includes BII, saw an increase in claims, with the claims ratio going to 77.8% in 2020 from 50.6% in 2019
- The response of the supervisory authorities to the claims of the insureds affected by the closures was different in each country
- So were the responses of insurers to their policyholders' complaints. This is logical: policies are not the same in all markets
- Ad ex., in Spain, loss of profit insurance is as an additional guarantee within a multi-risk policy and the coverage of business interruption is conditional on it deriving from previous material damage affecting the business premises

Effects on lines of insurance-Business Interruption

- However, in Spain, on the basis of judgements in the UK and France, which in some cases gave reason to the policyholders, insurers began to be ordered to pay the compensation foreseen for the case of closure even if there was no previous material damage, but a simple administrative closure decision
- These rulings assumed:
  - (i) that BII covers every interruption derived from any cause if there was not a specific exclusion. As the policies did not include a specific exclusion of pandemic or of closure decided by authorities, the insurers had to pay out. This thesis is incorrect, as BII is not an open perils insurance but a named perils insurance and the premium is calculated taking this account
  - (ii) other rulings decided that the clause requiring previous material damage was limiting the rights of insureds and to be valid should be highlighted and specifically accepted by the insured (art. 3 LCS). If these formal requirements were not met in the contract, the clause did not apply and the cover applied even when there was only an administrative closure decision
- Faced with an avalanche of claims, which was boosted by the first rulings in favour of policyholders, the insurers' association (UNESPA) advised them not to pay out

Effects on lines of insurance-Business Interruption

- 2021-2022: change of the trend and more and more rulings released insurers from all payments related to this risk
- 2023, 50% in favour of the insurers
- In the meantime, the insurers are including in the new contracts or at renewal, the exclusion of coverage of risks related to pandemics in some branches, including BII. They are using a clause very similar to the one drafted by Lloyd's for property insurance (LMA 5593)
- This position of insurers is logical, because they cannot bear the pandemic risk alone

Effects on lines of insurance-Business Interruption

- The problem of their coverage remains. It requires a public-private solution.
- In Spain, options:
- (i) to extend the functions of the Consorcio de Compensación de Seguros
- (ii) the government could launch parametric insurance programmes, as has been done in other countries with catastrophic risks

Effects on lines of insurance-Business Interruption

- Parametric insurance is particularly suitable to cover loss of profits due to business interruption for whatever cause.
- Traditional insurance covers property damage to the business premises and loss of profits resulting from the closure of the business until the defects are repaired.
- In contrast, in parametric insurance, there is no such interdependence between the property damage to the premises and the loss of profits that the entrepreneur may suffer.
- For the payment to be triggered, it is enough that the event described in the contract occurs in the area where the premises are located, even if there is no material damage. The event could be closure due to a pandemic.
- Moreover, even if the pandemic closure were covered by traditional insurance BI, the parametric insurance may be more useful:
  - (i) it may include losses arising from the closure of other businesses in the area that may affect the entrepreneur (e.g. distributors of merchandises that the undertaking sells to the consumers)
  - (ii) the compensation would be paid more quickly than in ordinary insurance
- In any case, some solution has to be found better than giving public aids after the crisis that came late and whose amounts are not correlated with the real damages suffered by the entrepreneur

Effects on lines of insurance- Life

- 2020-2021, the life insurance sector reversed the growing trends observed in previous years.
- Shift from products with guarantees towards index-linked and unit-linked insurance (EIOPA, 2021 Consumer Trends Report, pp. 10-11).
- The financial markets turbulence experienced after the outbreak of the Covid-19 pandemic and after the invasion of Ukraine seems not to have lowered the appeal of these products (EIOPA Financial Stability Report June 2023, p. 7).
- On the contrary, unit-linked have emerged as credible and popular investment plans that can help consumers addressing inflation risk (EIOPA Financial Stability Report June 2022, p. 33)
- This trend has its flip side, because of:
  - (i) the lack of transparency of these products,
  - (ii) the poor consumers understanding of the risks included in the risk-reward profile of unit-linked products (EIOPA, 2021 p. 11);
  - (iii) the lack of confidence of consumers about if their insurance offer them value for money (26% of Consumers, according to EIOPA Consumer Trends Report 2023, p. 35, believe their insurance does not offer them value for money);
  - (iv) investments in crypto assets via unit-linked life insurance raise value for money concerns (EIOPA Consumer Trends Report 2023, p. 35).

Effects on lines of insurance- Life

- Has the death by Covid been a problem in obtaining compensation from life insurers?
  - In the absence of a specific exclusion for Covid death or pandemic death, the insurer must pay out.
  - But, hypertension and diabetes have been found to be factors that increase the risk of Covid death, so insurers may refuse to pay if they discover that the policyholder did not disclose either of these conditions when they took out the policy (vid. https://www.eleconomista.es/catalunya/noticias/10722592/08/20/Los-seguros-de-vida-asumen-los-fallecimientos-por-el-coronavirus-.html)

Effects on lines of insurance-Motor vehicle liability

- Motor vehicle liability insurance (EIOPA 2021, pp. 13-14): registered a contraction of 2% in Gross Premium Rates in 2020 because of the pandemic
- Claims also decreased registering a drop of EUR 5,3 billion, leading to a drop in claims ratios in most Member States.
- The pandemic also highlights a need for further revision of insurance products to be adapted to changes in preferences and life/work modes.
- The pandemic has demonstrated that insurance usage-based and on-demand is very useful especially for cars.
- Types of insurance (on demand, pay-as-you-drive) that offer an adjustment of the premium to the risk automatically or in a short period of time might be a real advance.

Effects on lines of insurance- Health

- Although Covid-19 is a health issue, costs have not been a major problem for the sector.
- In Europe, the burden of costs has been borne by the public health sector. In fact, in Spain, 2 out of 3 Covid hospitalisations were in public hospitals, not in private ones
- In Spain: the saturation of the public health system led to a flight of citizens to private health care: (i) to get their consultations for any illness or (ii) to be treated surgically if they needed it
- EU in general: the role of the voluntary health insurance has been significantly less relevant than the public systems, but some concerns have been observed by EIOPA (CTR, 2021, pp. 22-23):
  - In 2020, the claims rejected increased significantly to 26.4% from 1% in 2019.
  - Huge difference between States: in France the increase of rejections was of 35%, while in Hungary or Spain there was no increase of rejections at all.

Effects on lines of insurance- Health

- On the other hand, there have been goodwill actions taken by insurers to pay claims, even when pandemics were clearly excluded in the policies, or in cases of delay or non-payment of premiums.
- In terms of coverage, many insurers covered, even without contractual obligation, daily allowances for Covid-19 hospitalisations, and expenses for diagnostic tests, among other measures.
- At the same time, we cannot forget that EIOPA ("Call to action for insurers and intermediaries to mitigate the impact of Coronavirus/Covid-19 on consumers", April 2020, p. 3) rejected the retroactive extension of coverage as a general measure stating that: "*It is important to recognise that in the case of a widespread pandemic, the pooling of risks necessary for insurance may be difficult to achieve, setting boundaries on what the sector can offer. As a general principle, imposing retroactive coverage of claims not envisaged within contracts could create material solvency risks and ultimately threaten policyholder protection and market stability, aggravating the financial and economic impacts of the current health crisis*".

Effects on lines of insurance- Health

- Problems to solve:
  - The lack of medical treatment of health issues different from Covid during the crisis can have led to a deterioration in insureds' state of health in coming years that could make future claims likely to be higher than estimated on the base of the original risk by insurers.
  - The desire of the customers in having additional health coverage including Covid-19 coverage is observed in practice.
    - In a first moment, it was observed that the insurers in many cases sought to exclude Covid-19 from future coverage, and to limit protection against future pandemics in new products, but
    - Now many insurers offers Covid protection: if the insurance has coverage for hospitalisation, the insurer will not be able to deny it because it is COVID-19

Effects on lines of insurance- Health

- In addition, some insurers have launched extra services or coverage, with or without cost, for their policyholders in relation to this illness:
- **Caser** health insurance. If you are not yet a client and you take out health insurance, the company offers a free serological test for the detection of COVID.
- **Asisa** health insurance. It includes the attention of coronavirus symptomatology, with the services, costs and limitations that mark their policies for the service that is required.
- **Axa** health insurance. Policies that include hospitalisation will maintain coverage, even if the reason for hospitalisation is coronavirus.
- **Sanitas**. Their health insurance policyholders specifically have a service called COVID-19 Medical Advisor.
  - If the policyholder has tested positive for coronavirus, a medical professional will accompany him/her and give him/her the appropriate recommendations during the treatment of the illness.

  See: https://seguros.roams.es/seguro-salud/coronavirus/

Effects on lines of insurance- Health

- Another problem to be addressed in Europe: exclusions of future consequences still unknown (the so-called “silent risk”) that could occur in the health of patients infected by Covid-19 during the pandemic
- In Spain, in relation to pre-existing conditions, a legal reform known as "oncological oblivion" has just been approved to prohibit discrimination against people who have overcome cancer when celebrating certain contracts, such as insurance. So:
  - In the pre-contractual phase of the insurance they will not have to declare that they have suffered from cancer, so that if they do not say so, the pre-contractual duty to disclose the risk cannot be understood to have been breached
  - A cancer that has already been overcome cannot be considered a pre-existing illness giving rise to an exclusion.
  - On the other hand, in relation to other diseases, such as those resulting from Covid, there is no limitation for insurers to question about them before underwriting or to exclude the pre-existing ones

I International Conference of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era

People with Disabilities and Access to Private Health Insurance: Recent Developments in Spain.

Universidad de Alcalá

PhD. Wilbemis Jerez Rivero

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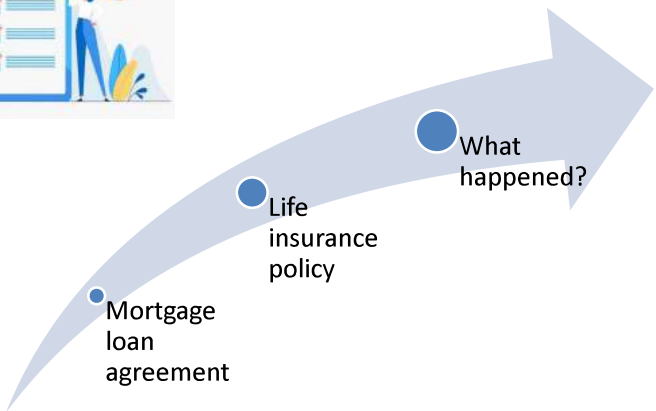
Is it a myth or a reality that people with disabilities face barriers to access private insurance in Spain?

Is discrimination based on disability or highly stigmatized health conditions legal in Spain?

We reflect...

Regarding the inquiry...



Background of the case

Ideas

Health questionnaire Medical report

Complaint to the insurer's Customer Service Department

General Directorate of Insurance and Pension Funds (DGSFP)

Can I turn to other authorities?

Claim in a judicial court

Civil route (Ordinary Protection Procedure)

Criminal route (for possible criminal typification)

Legal framework

Legal normative instruments and case law

-Spanish Constitution of 1978.

- Law 50/1980, of October 8, on Insurance Contracts.

- Law 4/2018, of June 11.

- Law 15/2022, of July 12, comprehensive for equal treatment and non-discrimination.

- Judgment 69/1994, of October 3.

-Judgment 62/2008, of May 26.

-Ruling of the Fourteenth Section of the Provincial Court of Madrid, dated November 16, 2022.

-International Convention on the Rights of Persons with Disabilities.

-Annual Report of the Ombudsman.

Well-founded response

Are there discriminatory practices based on disability or other highly stigmatized conditions in Spain?

Equal treatment and non-discrimination

Prohibition of denial of access to contracting

Barriers in contracting

To close…

Discrimination based on disability or other health condition constitutes a violation of the human rights recognized in the Spanish legal system.

Every person with a disability can access insurance contracts without discriminatory treatment that violates their recognized human rights.

In this regard, many people with HIV who approach insurers to sign life insurance contracts encounter barriers to their contracting associated with the stigma generated by the disease.

Therefore, as established by the relevant regulations, the reasons for denial must be based on 'justified, proportionate, and reasonable causes, which are documented in advance and objectively

Finally, in the event of a violation of such rights, the affected person can access extrajudicial and judicial avenues in order to receive effective protection of their rights.

So...

"An inclusive and fair future is envisioned when barriers to accessing insurance contracts for vulnerable individuals are eliminated, opening up opportunities and protection for all"

Thank you very much

Protecting biodiversity, protecting health: the role of insurance in protecting life on land and below water

1st International Conference of the Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era

Presented By
Vitor Boaventura Xavier

13 and 14 July 2023

Introduction

This paper aims to explore how insurance can contribute to protecting biodiversity systems on land and sea, ultimately contributing to achieving the sustainable development goals.

THE GLOBAL GOALS

Sustainable Development Goals

The Sustainable Development Goals (SDGs), also known as Global Goals, are a set of 17 integrated and interrelated goals to end poverty, protect the planet, and ensure that humanity enjoys peace and prosperity by 2030.

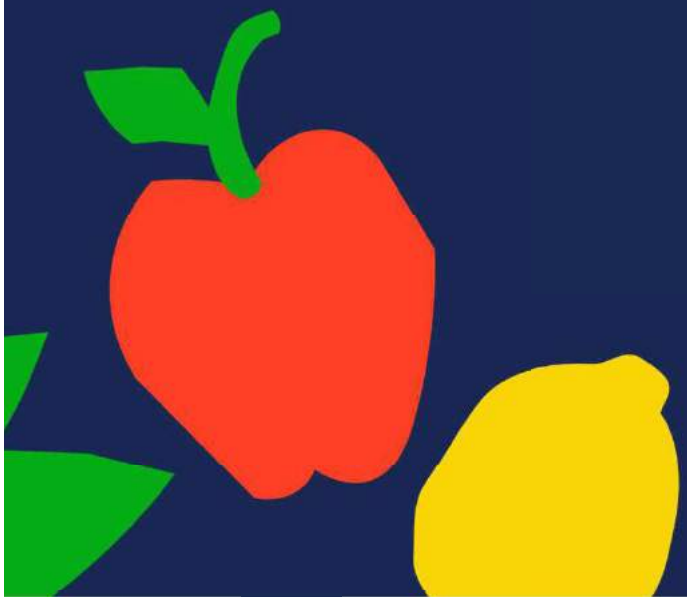
Reporting on the SDGs is important in communicating to stakeholders the company's commitment to contributing to the Global Goals; claiming accountability and responsibility to take the necessary actions; and measuring progress over time.

THE GLOBAL GOALS

Sustainable Development Goals

This reflection centers on the 3rd, 14th, and 15th sustainable development goals.

Theoretical and Empirical Assumptions



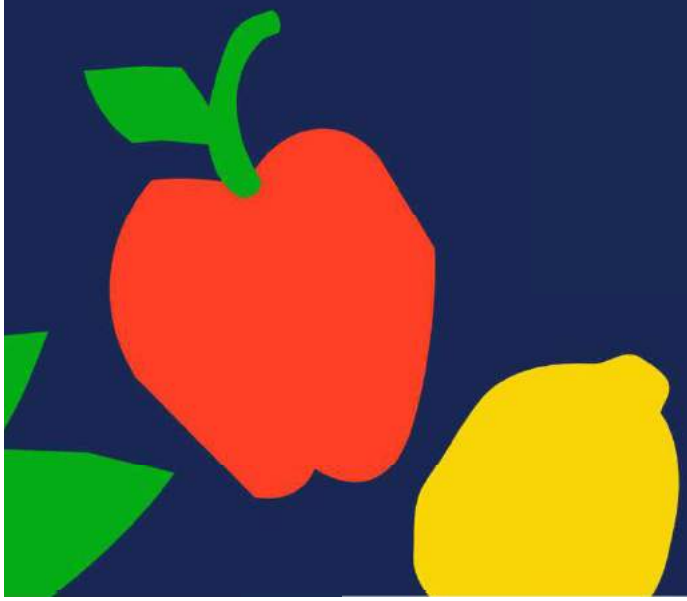
INSURANCE AS GOVERNANCE

Insurance, as a societal institution, can enhance governance function performance by adding value to society and achieving sustainable development goals. (Ericson, Doyle et al., 2003).

HOLLISTIC APPROACH TO INSURANCE REGULATION

The safeguarding of biodiversity systems is crucial for promoting good wealth and well-being as life is interconnected and mutually dependent.

Theoretical and Empirical Assumptions



HUMAN IMPACT TO BIODIVERSITY SYSTEMS

Damage to biodiversity systems can significantly affect human health and well-being.

INSURANCE SUPERVISION AND CONTRACT REGULATION

Insurance is important not only for indemnifying losses but also for preventing biodiversity loss and damage.

Challenges

MEASURING BIODIVERSITY	REGULATORY WEAKNESSES	CULTURES	MAKING BIODIVERSITY SEXY
• Inconsistency when it comes to measuring biodiversity impact • Biodiversity impact (positive and negative) might not be direct, but indirect	• Regulation is too loose to tighten • Regulatory normative framework and approaches were not designed to address the biodiversity related issues	• Bureaucratic cultures and inertia may break the will to incorporate biodiversity as a value to be pursued by insurance regulators and supervisors	• Another challenge relates to institutional capacity to add to the macroprudential analytical toolkit the necessary features to make sure biodiversity as a value becomes a tangible objective

Policy recommendations

Policy recommendations can be made to expand insurance contribution to protecting biodiversity in both land and sea ecosystems, aiding ongoing policy debates.

01

REGULATION

Rethinking the regulatory approach to consider not only solvency and systemic equilibrium as regulatory objectives;

02

UNDERWRITING

Incorporating Biodiversity Protection into Insurance Underwriting Processes.

03

BEHVIOURAL SUPERVISION

Biodiversity impact analysis could be included in the reporting rules for corporate governance and transparency for insurance companies.

Policy recommendations

Policy recommendations can be made to expand insurance contribution to protecting biodiversity in both land and sea ecosystems, aiding ongoing policy debates.

04

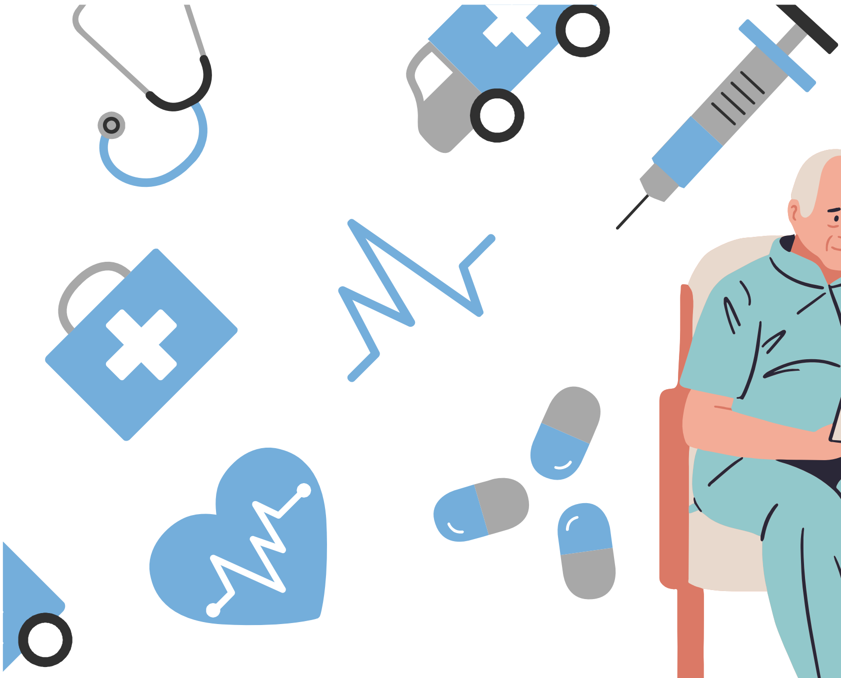
BUSINESS ETHICS

Biodiversity protection should not only be considered during underwriting but throughout the entire life of an insurance contract and the institutional actions of insurers as investors.

05

BIODIVERSITY GOVERNANCE

Insurance companies include biodiversity impact analysis as part of their reporting rules for corporate governance and transparency.



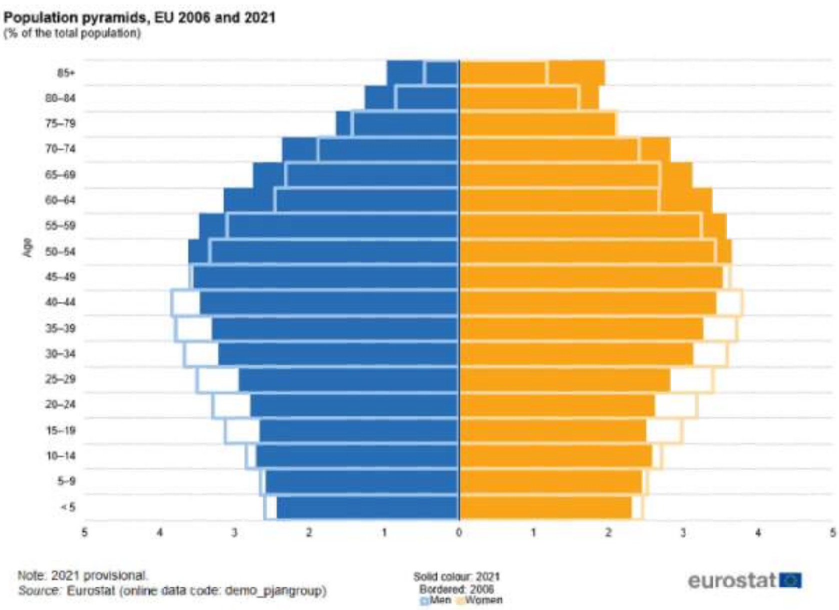
NOVA SCHOOL OF LAW

AGEISM AND ACCESS TO HEALTHCARE: INSURANCE CONTRACTS

Ana Pereira

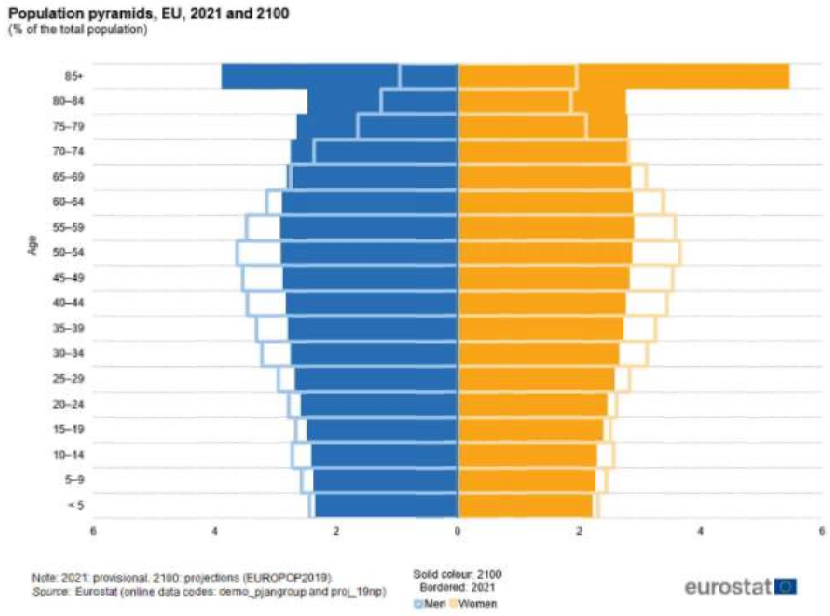
Introduction

WHAT'S HAPPENING IN THE EU?



Introduction

WHAT'S HAPPENING IN THE EU?



Introduction

SO, WHAT'S OUR PROBLEM?

So, access to healthcare is one of those. With the ageing of population, healthcare costs will keep undoubtedly increasing, and with the privatization of certain branches of healthcare systems a little bit all around Europe (and in Portugal's case, with a national healthcare system that unfortunately is failing its citizens) health insurance is slowly, but surely, becoming a necessity to most. As it's known, however, insurance companies often either don't offer health coverage from a certain age or the price they demand is often disproportionate and unbearable for the elderly.

So, we must ask a few questions:

WILL THE ACCESS TO HEALTHCARE SYSTEMS REMAIN ACCESSIBLE AND AVAILABLE TO THIS (EVER-GROWING) PART OF OUR POPULATION?

ARE WE DISCRIMINATING AGAINST A VULNERABLE GROUP? WHAT'S THE ROLE OF INSURANCE COMPANIES IN THIS?

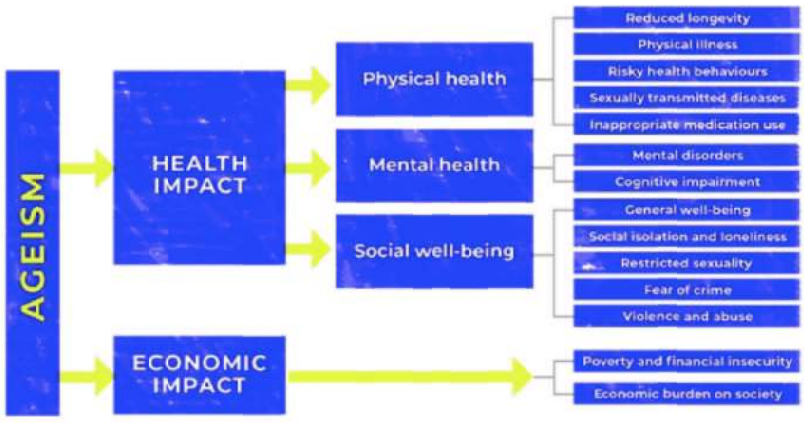
“

A MAN KNOWS HE IS OLD BECAUSE HE BEGINS TO LOOK LIKE HIS FATHER

Gabriel Garcia Marquéz

”

Age Discrimination



Source: WHO Global Report on Ageism (2020)

The Madrid International Plan of Action on Ageing

Article 10

The potential of older persons is a powerful basis for future development. This enables society to rely increasingly on the skills, experience and wisdom of older persons, not only to take the lead in their own betterment but also to participate actively in that of society as a whole.

Source: MIPAA, 2002

The Right to Health

WORLD HEALTH ORGANIZATION (WHO):

"A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" and states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

UNIVERSAL DECLARATION OF HUMAN RIGHTS

*"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, **medical care** and necessary social services."*

THE RIGHT TO HEALTH

International and communitary instruments

International Covenant on Economic, Social and Cultural Rights

Article 12

""States parties' recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"

UN Principles for Older Persons

Paragraphs 10-14

"Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness."

International Covenant on Economic, Social and Cultural rights

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

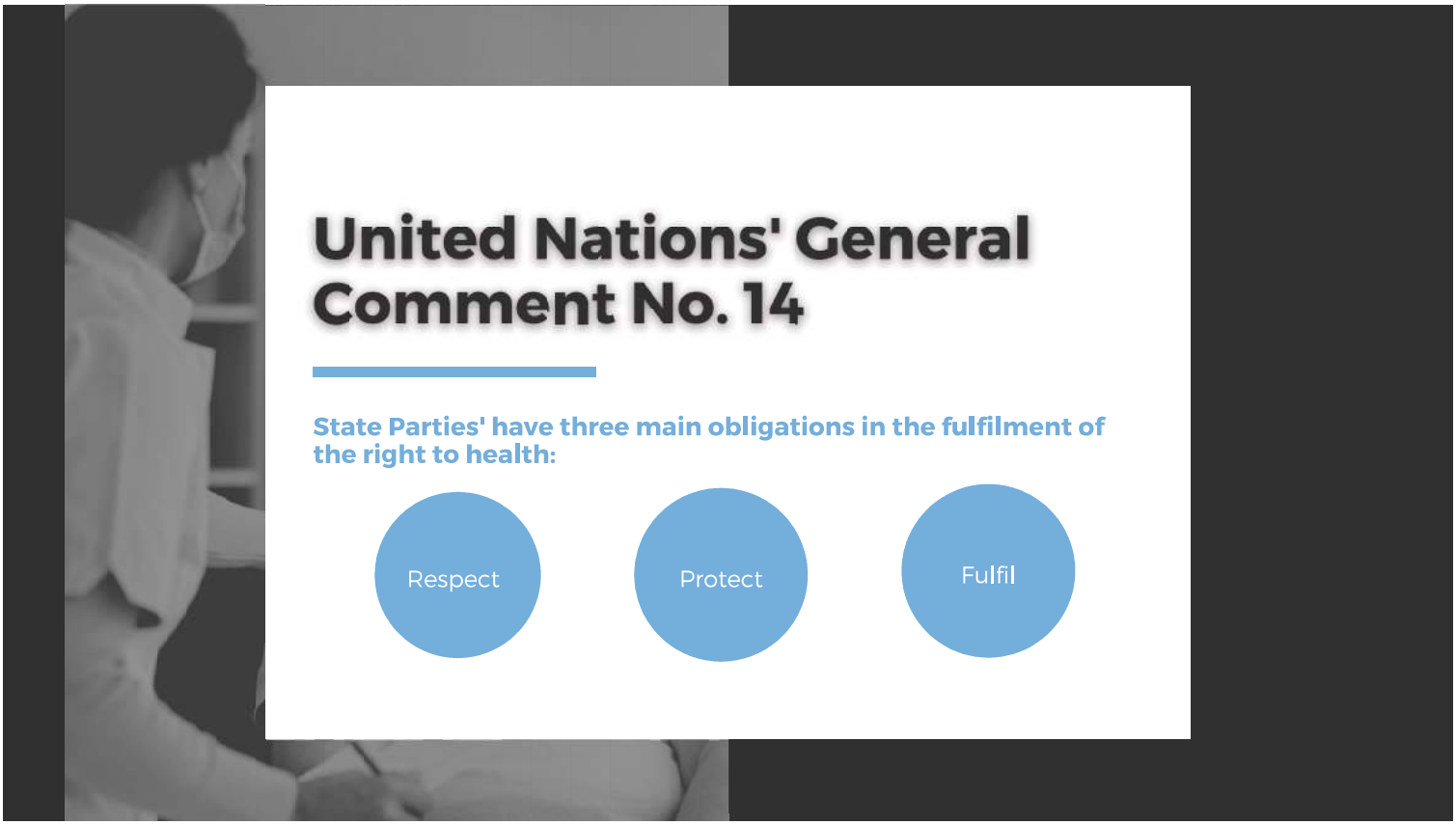
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.


United Nations' General Comment No. 14
State Parties' have three main obligations in the fulfilment of the right to health:
Respect
Protect
Fulfil


THE SGD'S: GOAL 3
Insurance can plug gaps in social safety nets, provide better household conditions and prevent household from falling back into poverty
3 GOOD HEALTH AND WELL-BEING
Lin Chiew, H. (2021, March 1). Insurance and the Sustainable Development Goals: Why it matters and how data can help [Press release]. https://a2ii.org/en/sustainable-development-goals; Access to Insurance Initiative, https://a2ii.org/en/media/5360/download.

LEGAL FRAMEWORK

What can we work with?

Solvency II Directive

Insurance Distribution Directive

THE RIGHT TO HEALTH

International and communitary instruments

European Social Charter

Article 23

Article 23 recognizes that, to enable elderly persons to choose their lifestyle and lead their lives as they wish, appropriate measures in the health care and health services in their State must be assured.

Charter of Fundamental Rights of the EU

Article 25 and Article 35

Article 25 of the Charter declares the "respect and right to the elderly to lead a life of dignity and independence"and finally, establishes on Article 35 that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities."

Biomedicine Convention

Article 3

Pursuant to Article 3, "parties, taking into account the health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality,"

Age Discrimination
The EU stance

In the EU, there is no specific directive or regulation prohibiting discrimination on the grounds of age in the access to financial services or in the area of healthcare.

Health Insurance

An insurance contract is a contract under which one party, the insurer, promises another party, the policyholder, cover against a specified risk in exchange for a premium.

Parties

Insured event

Premium and Risk

Warranty

*In **health insurance,** the insurer agrees to pay all or some of the insured person's healthcare costs in return for a payment of a premium, which is calculated according to the insured's risk of ill-health.*

Age: Is it a fair tool?

An insurance contract is a contract under which one party, the insurer, promises another party, the policyholder, cover against a specified risk in exchange for a premium.

Credibility

Reliability

Homogeneity

Accuracy

*In **health insurance,** the insurer agrees to pay all or some of the insured person's healthcare costs in return for a payment of a premium, which is calculated according to the insured's risk of ill-health.*

Conclusion

Discrimination on the grounds of age in insurance contracts is just the tip of the iceberg and we still have a long way to go, but the road isn't so dark anymore and insurance companies have a crucial role in this.

LEGISLATIVE APPROACHES REGARDING THE PROTECTION OF CONSUMERS INVOLVED IN LEGAL RELATIONS OF THE PROVISION OF CROSS-BORDER MEDICAL SERVICES. IMPROVING ACCESS TO HEALTH SERVICES. DESIDERATUM FOR THE 3rd SUSTAINABLE DEVELOPMENT GOAL

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Abstract: *In September 2015, the 2030 Agenda for Sustainable Development was adopted by the United Nations based on the 17 Sustainable Development Goals (SDGs), representing a policy framework designed to ensure a global balance between economic, social, health, environmental, etc.*

Sustainable Development Goal 3 entitled "Health and Well-being" has set as one of its goals the promotion of health by ensuring universal access to information, education, and counselling to promote prevention.

The citizen-oriented approach is different from the patient-oriented approach as it takes into account that before citizens become patients they must be informed and encouraged to protect their own health and to ensure a quality living environment centered on values, well-being and health. In this context, the Agenda for Sustainable Development places great emphasis on collaboration between state authorities, civil society, and the private sector, which must take the form of an effective contribution by all service providers, whether public or private, towards universal health coverage. In this respect, one of the concrete mechanisms for achieving prevention in terms of citizens' health is to facilitate or improve access to healthcare packages through health insurance contracts. In the private health insurance system, private health insurance contracts are characterized by flexibility in the sense that the insurer and the insured, depending on the needs of the latter, 'build' contractual clauses based on a main insurance plan as well as a supplementary prevention plan. Improving access to health services in the context of a sustainable global policy in which the citizen and not the patient, and in which prevention and not treatment, are the priority, will be the subject of this research.

Keywords: private health insurance, private health insurance contract, insurance policy, insurance premiums

I. "Health and well-being" - common objective of the European Union and the United Nations, for a sustainable future

- In September 2015- the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development
  - *a document that provides a framework for action for the next 15 years in order to eradicate poverty, combat inequalities worldwide, by promoting inclusive and equitable development, based on respect for human rights.*

- The European Union, known worldwide as a promoter of the "rules-based international order" has joined the UN in its effort to build a better world for all. Therefore, the two "natural partners", the European Union and the UN, have assumed the fulfillment of the SDGs, considering them useful tools to project values and benchmarks worldwide.
- At the EU institutional level, we note the involvement and constant support of the 2030 Agenda, by the European Council and the European Commission.
- The European Commission, through the voice of President Ursula von der Leyer, reaffirms its firm commitment to the 2030 Agenda for sustainable development, so that its political program integrates the SDGs into all proposals, policies and strategies of the European Commission, specifically all 17 objectives are found in one or more of President von der Leyen's six political guidelines:
  - (a) European Green Deal;
  - (b) economy that works for people;
  - (c) European fit for the digital age;
  - (d) European model of living;
  - (e) Europe stronger in the world;
  - (f) European democracy.

I. "Health and well-being" - common objective of the European Union and the United Nations, for a sustainable future

- SDG 3 entitled "Health and well-being" is an integral part of the 2030 Agenda, being one of the most important pillars of the program.
- Some of the SDG 3 ***objectives***:
  - (i) Achieving universal health coverage, including financial risk protection, access to quality essential health services and access to essential medicines;
  - (ii) By 2030, substantially reducing the number of deaths and illnesses caused by hazardous chemicals, pollution and air, water and soil contamination;
  - (iii) By 2030, ensuring universal access to sexual and reproductive health services, including for family planning, information and education, as well as the integration of reproductive health into national strategies and programs;
- We find that one of the objectives assumed within SDG 3 is the promotion of health and medical prevention by ensuring access to information, education, counseling services, as well as to the most diverse national and international medical services.
- Therefore, health insurance in general and private health insurance, in particular, are instruments with the help of which the desired goals assumed in the framework of SDG3 become realities.

II. Romania's policy, part of the Union policy for implementing the objectives of the 2030 Agenda

Romania has taken important steps towards the national implementation of the 2030 Agenda, creating the institutional and strategic premises for its successful transposition.

- In this sense, the Department for Sustainable Development was established, by Government Decision no. 313/2017. The department operates within the working apparatus of the Government, subordinated to the Prime Minister, financed from the state budget through the budget of the General Secretariat of the Government. The department is currently coordinated by State Councilor László Borbély. We note as its main functions:
  - (a) coordination of activities to implement the result from the set of 17 sustainable development objectives - SDG of the 2030 Agenda;
  - (b) monitoring the indicators of sustainable development established at the level of the European Union and at the level of the United Nations Organization, as well as the specific indicators, adapted to Romania's conditions, with regard to possible gaps and on the measures to remedy them;
  - (c) formulating proposals for adjusting the national target objectives and their deadlines;
  - (d) the implementation, as well as the identification of new necessary indicators depending on both the real and de facto situation ascertained by the provisions of the European Union directives on the matter, adapted along the way.
- At the same time, the ***"National Strategy for Sustainable Development"*** was adopted, a strategy through which Romania establishes its national framework for supporting the 2030 Agenda and implementing the set of 17 SDGs. The strategy supports Romania's development on three main pillars, namely economic, social and environmental. The strategy is citizen-oriented and focuses on innovation, optimism, resilience and confidence that the state serves the needs of every citizen, in a fair, efficient and clean environment, in a balanced and integrated way.

II. Romania's policy, part of the Union policy for implementing the objectives of the 2030 Agenda

Regarding the transposition of SDG 3 in Romania, this is done through a complete approach in the sense that objectives are considered as identified in the two programs suggestively named "Horizon 2020" and "Targets 2030", both programs following:

- Promoting health education, prevention and a healthy lifestyle;
- Modernizing and rehabilitating public health infrastructure to average European Union standards, with emphasis on the rural area, including supporting medical research;
- Implementation of a transparent and reliable system for the penetration and management of medicines, devices, equipment and medical equipment on the Romanian market, to increase the population's access to the newest and most efficient diagnostic and treatment technologies;
- Improving the diagnostic and treatment capacity through the implementation of E-health services; the development of screening and early diagnosis operations for non-communicable diseases with an impact on public health;
- Ensuring universal access to information, education and counseling services to promote prevention and adopt a risk-free lifestyle, etc.

III. Legislative regulations regarding private health insurance in Romania. Conceptual boundaries. Characteristics.

- ✓ The health system outlined in Romania by ***Law no. 145/1997*** and later taken over by ***GEO no. 150/2002*** repealing the mentioned law, is one of the Bismarck type.
- ✓ The reform in the sanitary field had as its legal basis Law no. 95/2006, which repealed, among others, GEO 150/2002. This law, through Title VII - titled "Social Health Insurance" redefined the entire public health social insurance system in Romania managed by the National House of Health Insurance, established by Law 145/1997.
- ✓ With reference to private health insurance, they were regulated in Romania, quite late, by ***Law no. 212/2004***.
- ✓ Considering the legislation appropriate to the insurance matter in Romania, we can make the following remark, that at the base, the public health system is identified, in which a person who is insured receives a health card that he can use whenever comes into contact with a medical service provider who has a contract with the National Health Insurance House.
- ✓ The possibility of accessing medical services at private clinics for a fee or through private medical subscriptions is also retained.
- ✓ Those who benefit from a private medical subscription are, in principle, the employees of the multinational companies that offer this benefit. There are also people who prefer to personally pay a medical subscription either for themselves or for other family members.
- ✓ A third option, and the most favorable in terms of prevention as well as treatment of the health condition, is private health insurance.

IV. The appropriate legislative framework regarding the private health insurance contract

- ✓ Pursuant to art. 1 of Law no. 212/2004, the regulatory field is private health insurance for the payment of medical services, which constitutes an optional system, in addition to the mandatory health insurance, which covers the insured, medical services under the terms of the legislation on the organization and operation of the social health insurance system.

Who can conclude a private health insurance contract? Or, in other words, who can have the capacity of insured/consumer of the private medical service?

- ➢ The answer is given by the Romanian legislator, who in art. 4 par. (1) and (2) in conjunction with art. 5 par. (1) and (2) of Law no. 212/2004 identifies the categories of persons eligible for the services offered by the private health insurance system, respectively:
  - ❖ *"any person, Romanian citizen, foreign citizen or stateless person with domicile or, as the case may be, residence on the territory of Romania who, after fulfilling the mandatory requirements of social health insurance, concludes contracts with private health insurance companies, hereinafter referred to as insurers, and pay the insurance premium.*
  - ❖ *"citizens of the member states of the European Union, as well as citizens of the states with which Romania has concluded agreements, understandings, conventions or international cooperation protocols in the field of health and medical sciences are eligible for the services offered by the private health insurance system and without fulfilling the mandatory requirements of social health insurance, if the agreements, understandings, conventions or protocols concluded between Romania and the respective country do not provide otherwise".*
- ➢ It is important to clarify the fact that the text of the normative act states in the sense in which, the capacity of contracting party in a private health insurance contract can have as the case may be:
  - ❖ natural persons who have a private health insurance contract concluded with an insurer, individually or by a third person; and,
  - ❖ employers, natural or legal persons, may conclude private health insurance contracts for their employees, individually or in groups, granted as additional benefits to their salary rights, to attract, select and stabilize employed personnel.

IV. The appropriate legislative framework regarding the private health insurance contract

Who are private health insurance companies/private medical service providers?

- ✓ Private health insurance offered by private health insurance companies are medical services established by each private health insurance company in the form of service packages, depending on the individual risk.
- ✓ In the sense of art. 3 of Law no. 212/2004, private health insurance can be complementary, additional and substitute insurance.
  - ✓ In concrete terms, complementary private health insurances fully or partially support the payment of services partially excluded by social health insurances from the basic package, including co-payments, as the case may be.
  - ✓ Additional private health insurance fully or partially covers the payment for services that exceed the basic service package in the social health insurance system regarding the provision of a high degree of comfort, rapid access to medical services in the case of waiting lists, special medical services in abroad and other services.
  - ✓ Substitutive private health insurance fully or partially covers the payment for any type of services, including those covered by social health insurance.
- ✓ As regulated in art. 13 paragraph (2) of the framework law, private health insurance activity is based on the conclusion of an insurance contract between natural or legal persons, as insured persons, and medical service providers, as insurers.

IV. The appropriate legislative framework regarding the private health insurance contract

The private health insurance contract represents a variation of the insurance contract defined *lato sensu*, within the Romanian Civil Code at art. 2199, as the convention by which "*the insurance contractor or the insured undertakes to pay a premium to the insurer, and the latter undertakes, in the event of the occurrence of the insured risk, to pay an indemnity, as the case may be, to the insured, the beneficiary of the insurance or the injured third party*".

- ✓ We find that the text of the Romanian Civil Code uses the terms insurance contractor and insurance beneficiary, terms that must be analyzed in the light of the provisions inserted in art. 5 paragraph (1) and (2) of Law no. 212/2004, i.e. both natural persons who contract private health insurance individually and employers, natural or legal persons, who can conclude private health insurance contracts can be insurance contractors, this last situation, implies the presence "insurance beneficiaries", these being, as the case may be, employees of the contractor, determined individually or in a group, within the insurance contract.
- ✓ Pursuant to art. 19 of Law no. 212/2004, through the private health insurance contract, the insured undertakes to pay a private health insurance premium (to be paid by the individual or his employer, quarterly, semi-annually or annually) to the insurer, and the latter obliges that, upon occurrence of one of the risks assumed by the contract, to pay, on behalf of the insured, the type of medical services, depending on the quantity and quality of the medical act and the individual risk and other services received from the medical service providers , within the limits and at the agreed terms, as well as the related expenses related to the respective services. We note that the insurer only settles the value of proven medical services, according to the contract and the insurance policy.

V. Types of private health insurance in Romania. International medical services

In Romania, any natural person, Romanian citizen, citizen of a member state of the European Union, foreign or stateless citizen with domicile or residence on the territory of Romania, has the opportunity to access an extensive range of private medical services offered by insurances that operate on the territory of Romania in accordance with the relevant legislation.

- In the following we will exemplify several such types of insurance that we believe cover, in terms of health, both the prevention and the medical area, with national but also cross-border coverage, with all the specific implications.

A first example in this sense is given to us by the Metropolitanlife insurer, which makes available to the consumer of medical services, the following medical insurance packages:

- ***Ultramed health insurance***
- ***Extramed health insurance***
- ***Smart Protect health insurance***. This health insurance provides financial protection in the event of being diagnosed with one of the following conditions: cancer - specifically, any form of malignant tumor, including leukemia, sarcoma and lymphoma (but not and cutaneous lymphoma); narrowing or blocking of the coronary arteries; deficiencies of the heart valve, which require surgical interventions; neurological conditions leading to brain or intracranial structure surgery; conditions requiring an organ or bone marrow transplant. This insurance provides access to the innovative "Top Protect" clause which involves additional financial benefits, namely:
  - second medical opinion, provided by an international expert doctor - confirming or denying the existing diagnosis;
  - recommendation of a personalized treatment plan and specialized medical institutions in the world (except Romania, USA, Japan and Switzerland)
  - Payment of a daily hospitalization allowance, to cover other expenses, at the choice of the Insured;
  - Coverage of treatment at specialized medical institutions (recommended by the Further partner);
  - Continuation of medication upon return to the country.
  - We make it clear that a Smart Protect private insurance contract with a "Top Protect" clause offers financial coverage of up to 2 million euros, being concluded for a period of 10 years, the insured's entry age being between 0 and 55 years old.

V. Types of private health insurance in Romania. International medical services

Another example is provided by the Signal Iduna insurer, which contracts three types of private health insurance, namely:

- ***360 Care***
- ***Vital Care***
- ***Take Care***

- ***360 Care-*** is a private health insurance "with coverage from any angle you look at", mainly focused on prevention with coverage both in Romania and in the European Union but also Turkey. In this type of package, services such as outpatient (consultations, laboratory tests, investigations and treatment, imaging services, medical recovery as a result of the disease), hospitalization and surgical interventions (including hotel services for the companion) additional services (annual check-up outpatient preventive care, telemedicine, second opinion, dedicated medical consultation, 0 damage plan limit increase), three access methods (direct settlement in the Mediqa Net network, reimbursement of payments from own funds, advance payment on the Easy Pay bank card) customer support (Call Center 24/7, dedicated application for mobile and web - Signal Care Assistant). This type of insurance provides services both in Romania (Plus Plan, up to 90,000 lei per year/ Premium Plan up to 150,000 lei per year) as well as at the level of the European Union or in Turkey (Premium Plan within the limit of 150,000 lei per year only in terms of hospitalization and surgical interventions)

V. Types of private health insurance in Romania. International medical services

- ***Vital Care*** - is a private health insurance with "care for you from the first diagnosis" with coverage both in Romania and in the European Union but also Turkey in case of cancer diagnosis. This type of insurance provides services such as: outpatient (consultations, laboratory analyses, investigations and treatment, imaging services, medical recovery as a result of the disease) hospitalization and surgical interventions, well-being coverage (e.g. reconstructive plastic surgery, psychological counseling, etc.) additional services (second opinion, dedicated medical consultation, treatment coverage for the diagnosed person even after the contract expires, until the plan limit is used up), three access methods (direct settlement in the Mediqa Net network, reimbursement of payments from own funds, advance payment on Easy Pay bank card) customer support (Call Center 24/7, dedicated application for mobile and web - Signal Care Assistant). It is important to specify that this insurance provides services both on the territory of Romania (Plus Plan, within the limit of 90,000 lei per year/Premium Plan within the limit of 100,000 lei per year) and at the level of the European Union or in Turkey (Premium Plan within the limit of 200,000 lei per year).

- ***Take Care-*** is a private health insurance, with coverage for hospitalization and surgical interventions, both in Romania, in the European Union and in Turkey. This type of insurance provides services such as: hospitalization and surgical interventions (including hotel services for the companion) additional services (second opinion, dedicated medical consultation, limit increase plan for 0 claims), three access methods (direct settlement in the Mediqa Net network, reimbursement of payments from own funds, advance payment on Easy Pay bank card) customer support (Call Center 24/7, dedicated application for mobile and web - Signal Care Assistant). It is important to specify that this insurance provides services both on the territory of Romania (Plus Plan, within the limit of 90,000 lei per year/ Premium Plan within the limit of 150,000 lei per year) and at the level of the European Union or in Turkey (Premium Plan within the limit of 150,000 lei per year).

V. Types of private health insurance in Romania. International medical services

The unique payment instrument in Romania – Easy Pay

- ✓ is a bank card that offers the possibility of paying in advance for a necessary medical service. It complements the traditional payment options (direct settlement or reimbursement). This method of settlement is made available to the insured by the insurer Signal Iduna, the benefit being that although its collaboration is limited to 900 clinics on the territory of Romania, through this card it is possible to access the medical services covered by the insurance, outside the Mediqa network Net, in any medical facility in the country, without the need for advance payment from the insured's money.
- ✓ Paying with the Easy Pay card is a unique and innovative method that provides simple and quick control over access to medical services. The payment will thus be made through a bank card supplied by the insurer. The medical service consumer will only have to notify 48 hours before going to the doctor to make the payment on the card.
- ✓ Another benefit of the Easy Pay card is that the documents sent in original are no longer necessary (invoices, receipts, medical report), so you can forget about the classic reimbursement files. The method was quickly adopted by all those who value flexibility and accessibility. This tool successfully complements the Signal Care Assistant mobile app, Signal Iduna policyholders can enjoy a 100% digital experience.
- ✓ Not only individuals can enjoy this system of advance payments for a medical service, but also the employees of numerous multinational companies located in Romania, who as employers have decided to include this unique benefit in the extra-salary package.

What are the advantages of the Easy Pay card?

- First, the Easy Pay card offers access to all medical units located on the territory of Romania. Secondly, payment via Easy Pay involves a faster process than in the case of classic reimbursement. Finally, we can talk about an advance payment for medical services.

In conclusion, whenever the consumer of a medical service calls for settlement through the Easy Pay card, the following steps will be considered:

a. the consumer of the medical service makes an appointment at the clinic;
b. the consumer of the medical service calls the Call Center -021 9910- and authorizes the medical service;
c. the Easy Pay card will be charged with the amount requested by the Signal Iduna insurer;
d. the consumer of the medical service benefits from the medical service and pays with the card;
e. the consumer of the medical service will send the requested documents (invoice, receipt, medical report) to the Signal Iduna insurer.

Conclusions

- ✓ Private health insurance is an effective mechanism for achieving SDG 3 entitled "Health and well-being".
- ✓ Thus, we believe that they encourage healthy behavior, emphasizing medical services that ***provide prevention***. Specifically, medical service providers support and encourage that type of behavior that focuses on constantly checking the state of health. Such an active attitude means care and attention for one's own person.
- ✓ Also, private health insurance ***gives flexibility*** to the medical service through recommendations regarding national and international clinics, the insured being the one who chooses the provider of medical services, both in the preventive area and the classic area of medical insurance, namely those with reference to medical tests, consultations, hospitalizations, surgical interventions.
- ✓ In the framework of private health insurance, the insured consumer benefits from ***personalized medical solutions***, these being determined through an honest dialogue with an available consultant.
- ✓ Private health insurances have ***high addressability***, so private policies offer the possibility to switch from one provider of medical services to another, but also the possibility to be consulted by a doctor at the choice of the insured/consumer of medical services. In addition, the private policy guarantees access to a second medical opinion.
- ✓ Finally, private health insurance is ***tax deductible***, both in the case of those provided by the employer and in the case of those concluded individually. (According to the Romanian framework law, these policies can be deducted up to a cumulative level (employee and employer) of 800 euros per year (the equivalent in lei) for each person).

SDG3, *legal design* and new technologies in life and health insurance

ANTHONY NOVAES

CARLOS ACOSTA

JULY 2023

SDG 3 vs LIFE & HEALTH INSURANCE

SDG 3: ensure a healthy life and promote well-being for all people at all ages

Challenges: Social and economic inequality and low penetration of insurance products for certain people and regions

Adequate measures: thoughtful public policies to expand access, expansion of network and strategic allocation of professionals and providers

ESG AGENDA

ESG Agenda: A framework for understanding and measuring the degree of sustainability.

Origin: UN-led initiative in 2004. Nowadays, Agenda 2030.

Agenda 2030: global goals based on four main dimensions: social, environmental, economic, and institutional. To this end, transformative measures were proposed, being 17 goals and 169 interconnected global targets, whose deadline for fulfillment is 2030 - becoming known as the United Nation's "Agenda 2030".

ESG & INSURANCE: A LIFELONG CONNECTION

UN-backed Initiatives: Principles for Responsible Investment (PRI), Principles for Sustainable Insurance (PSI), and the 2021 Application Paper on the Supervision of Climate-related Risks in the Insurance Sector (IAIS)

Sector initiatives: Global Federation of Insurance Associations (GFIA)

Axes: Environmental and liability insurances, risk assessment, investment criteria, diversity and inclusion (D&I)...

LEGAL ASPECTS

Potential: (i) minimize risks, and (ii) development of a more sustainable, inclusive, and environmentally friendly society

Risks: financial exposure for the Insurance ecosystem (e.g. pension funds) and new Sustainability-related risks (e.g. climate change)

EIOPA: 2023-2025 Work Program focused on sustainable finance, including efforts to finance the transition for a sustainable economy – 7 (seven) key areas

LAW FOR SUSTAINABILITY

Goal No. 16: Peace, justice and effective institutions

Paradigm change: Law at the service of society, i.e., user-centered Law

Impacts: Citizen-centered governments (via more efficient and clear legislation, rules and regulations) and legal practitioners delivering more relevant services

ENSURING PEOPLE-CENTERED LAW: LEGAL DESIGN

Premise: leaving behind a reality designed by legal professionals and lawmakers for themselves

Legal Design: combines innovation and legal knowledge with a focus on the user experience, so that the law is made clearer, more accessible and more efficient, upon the use of human-centered design

Layers: Information Design, Product Design, Service Design, Organizational Design and System Design

Axes: Visual Law, UX Writing & Plain Language

LEGAL DESIGN & INSURANCE

Industry struggles: balancing customer service and legal certainty

Effectiveness examples:(a) legislation, which people, organizations, and the public sector can more easily understand, and, therefore, more easily adhere to, and (b) insurance policies, by restating the legal aspects and enabling a better understanding of their terms and conditions

Practical outcomes: user-friendly legal documents that simplify the conduct of business and meet consumers' needs

LEGAL DESIGN & INSURANCE

Features to consider:

(i) plain and objective language

(ii) a design whose structure simplifies understanding

(iii) an intention to assist the parties in cultivating a positive relationship

(iv) content organized to achieve the objective of the contract, and

(v) balance, generating collaboration and trust

LEGAL DESIGN & ESG

Tools: for each of the axes of the acronym, legal design has a corresponding tool and benefit

→ Use of visual elements, informational hierarchy and appropriate design and writing techniques (such as plain language) facilitates understanding and increases the pregnancy of information

→ Use of digital solutions instead of physical formats leads to lower carbon dioxide emissions (CO_2) and less use of paper

→ In the social aspect, communities and individuals are empowered and can make better informed decisions, which is a clear positive impact

→ A friendlier relationship is expected to result in a reduction of administrative, judicial, arbitration and other types of litigation and conflicts

→ New and better standards, along with better communication, lead to social pacification

SDG3 & SPECIFICITIES

Goal No. 3: Ensure healthy lives and promote well-being for all at all ages" and it is subdivided into 13 (thirteen) targets

Objective: Large and ambitious - radically including vulnerable populations and making access to health services universally available

Axes: (i) maternal mortality, (ii) preventable deaths under 5yo, (iii) communicable diseases; (iv) non-communicable diseases and mental health, (v) substance abuse, (vi) road injuries and deaths, (vii) universal health coverage, (viii) hazardous chemicals and pollution-related diseases

LEGAL DESIGN IN INSURANCE FOR SDG3

Examples of use:

-Simplifying Policy Wordings

-Designing User-Friendly Claims Processes

-Implementing Digital Consent Mechanisms

-Facilitating Dispute Resolution

-Incorporating Inclusive Design for Vulnerable Populations

NEW TECHNOLOGIES IN INSURANCE

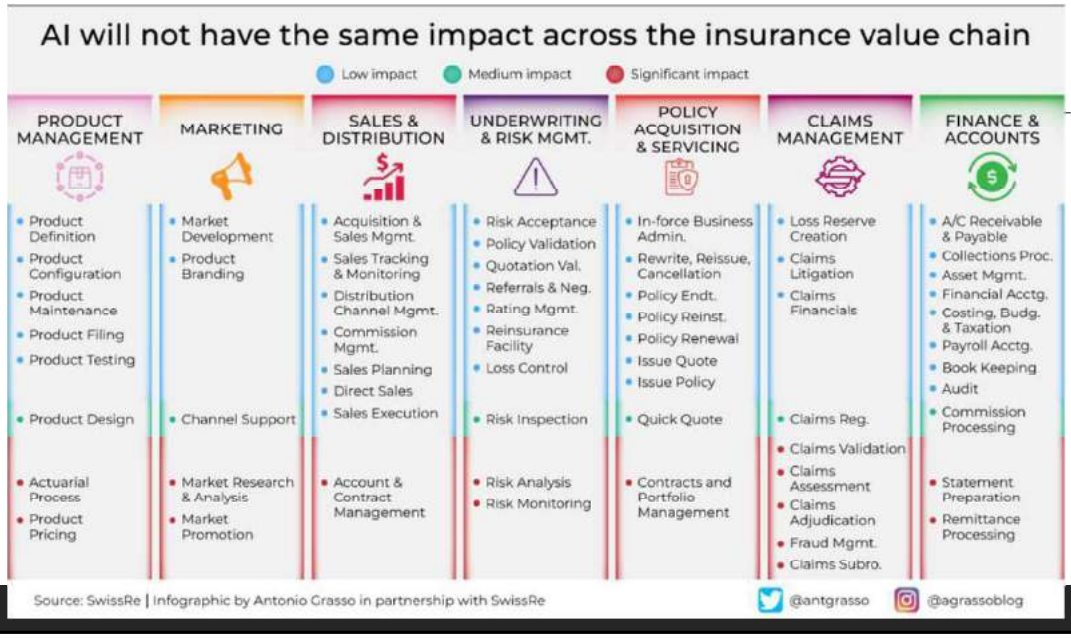
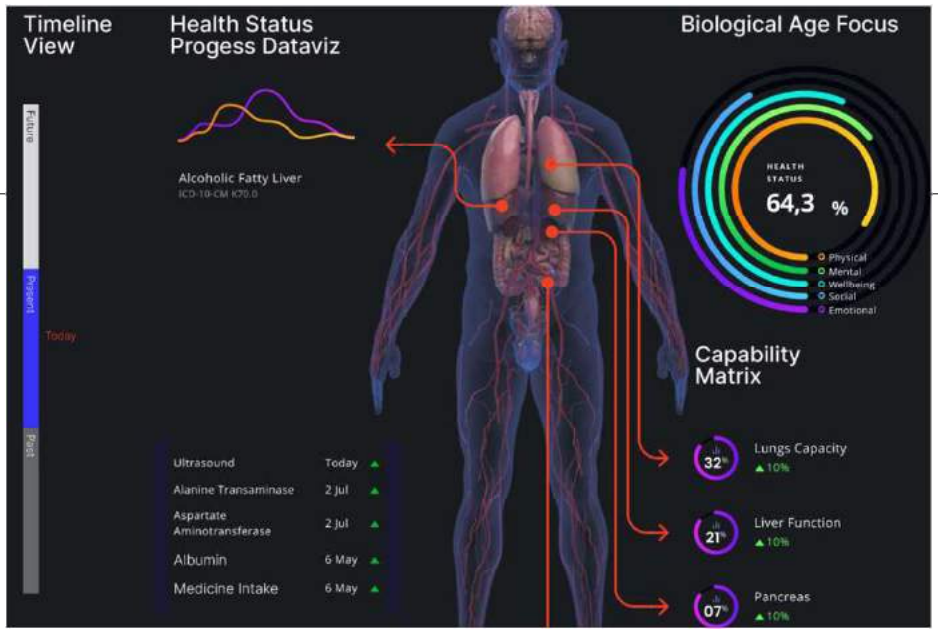


Figure 9. Smart homes integrated with automated systems for elderly healthcare.

Resource: Majumder, Sumit, Emad. Aghayi, Moein Noferesti, Hamidreza Memarzadeh-Tehran, Tapas Mondal, Zhibo Pang, and M. Jamal Deen. 2017. "Smart Homes for Elderly Healthcare–Recent Advances and Research Challenges" Sensors 17, no. 11: 2496. https://doi.org/10.3390/s17112496



Resource: Intelligent Assist https://iamyhealth.com/index.html

NEW TECHNOLOGIES IN HEALTH INSURANCE FOR SDG3

Examples of Use:

- Personalized Wellness Programs
- Risk Assessment and Premium Customization
- Early Intervention and Disease Prevention
- Prompt Claims Management
- Remote Health Monitoring for Chronic Conditions
- Gamification

PUBLIC POLICIES: GENERATING EFFECTIVE CHANGE

Examples:

-Universal Health Coverage (UHC)

-Health Education and Promotion

-Mental Health Services

-Access to Essential Medicines

-Healthcare for Vulnerable Populations

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Interventions from the Market:

Some Policy Recommendations

Carlos Suarez, CEO of Victoria-Seguros

The partnership that VICTORIA Seguros has had since 2020 with the exponential medicine unit of the faculty of medical sciences at Universidade Nova de Lisboa - materialized in its Chair in Healthy Building - is already being applied in terms of public policy.

The Chair seeks to create a Health - Real Estate ecosystem that fosters the sharing of knowledge and the development of solutions, methodologies, and strategies aimed at materializing, optimizing, and providing access to public and private spaces that support quality of life and promote the health of their occupants.

In other words, the VICTORIA Seguros Chair in Healthy Building seeks human sustainability in all buildings, whether public or private. It is within this framework that the Living Lab Cascais SeU: Health and Urbanism was created, with an action program aimed at qualifying healthy buildings and public spaces.

Increasing the quality of buildings - based on biomedical/scientific evidence and founded on the universal principle of human sustainability - promotes the health of the entire population and should therefore become a public policy issue, a priority on the legislator's agenda, a necessity for local public decision-makers.

Initiatives such as the VICTORIA Seguros Chair in Healthy Building at Nova Medical School help to achieve this goal, but only with political impetus can it be fully realized.

Ana Mota, Board Advisor to MDS

The dichotomy between the insurance market's supply, which is technically sustainable in the medium and long term, and the economic capacity of families and companies to pay premiums, is one of the biggest challenges facing health insurance in the future.

Demand is growing, but high health inflation could strangle the space for health insurance coverage in society.

It would be different, or at least this effect would be lessened, if health policies started to think about an Integrated Health System (combining public and private provision) and not just focussing on the NHS in a stand-alone way.

Summarizing the Policy Recommendations: A Way Forward

Policy Recommendation Briefing no. 1

Prof. Margarida Lima Rego

Coordinator

Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era

On 13 and 14 July 2023, NOVA School of Law and AIDA Portugal, the Portuguese section of the International Insurance Law Association, organized the 1st International Conference of the Jean Monnet Module on European Union Insurance Law: Challenges in the SDG Era, funded by the European Commission's Erasmus+ Programme. The Jean Monnet Module is led by Professor Margarida Lima Rego, Full Professor and Dean of NOVA School of Law (Portugal), Professor Maria del Val Bolívar Oñoro, Professor at the University of Alcala (Spain), is the second scientific coordinator of this Module. Professor Maria Elisabete Ramos, Guest Professor at NOVA School of Law and Assistant Professor at the School of Economics of the University of Coimbra (Portugal), completes the team of scientific coordinators of its conference series.

The conference was the first in a series of annual conferences, all dedicated to different sustainable development goals. In 2023, the conference was dedicated to SDG 3 - Good Health and Well-Being.

For a day and a half, the conference welcomed world-renowned speakers from various backgrounds to discuss the important role played by the insurance sector in promoting the health and well-being of the entire population in contemporary societies.

On a national level, it is worth highlighting the speech by Margarida Corrêa de Aguiar, President of ASF, the Portuguese Insurance and Pension Funds Supervisory Authority, for whom "society in general, economic agents and political decision-makers expect the insurance sector to play a growing and effective role in guaranteeing the protection and

compensation of losses resulting from increasingly diverse and severe risks". Margarida Corrêa de Aguiar said that, in Portugal, health insurance is a complementary pillar of the National Health Service. "In a decade, gross premiums written for direct insurance went from 523 million in 2012 to 1,156 million euros in 2022, which corresponds to a growth of 120%. And if we narrow down the observation period from 2019 to 2022, health insurance production has increased by 34 percent, much more than the growth in national GDP over the same period."

The President of ASF announced that this institution "has categorized investment in a series of initiatives aimed at improving the quality of health insurance regulation and supervision as a strategic priority in its latest activity plans. This concern is linked to the growth of health insurance in our country, which by the end of 2022 covered 3.5 million beneficiaries." Among the initiatives to be highlighted, she referred to the construction by ASF of a Portal dedicated to health insurance and a Permanent Health Insurance Observatory.

Professor Pedro Pitta Barros, holder of the BPI | "la Caixa" Foundation Chair in Health Economics at the Nova School of Business and Economics and the first keynote speaker at the conference, contrasted these figures with some others, showing that, despite the growing penetration of health insurance in Portuguese society, according to data provided by the National Statistics Institute, the insurance sector only supports around 4% of current health expenditure, a much lower percentage than direct household expenditure on financing the Portuguese health system, which is 29%. In Portugal, the main source of funding for the health system continues to be public spending, which in 2021 accounted for around 66 percent of total health spending.

In the first of a series of conferences announcing the intention to take an active role in the preparation, discussion, and open-access dissemination of public policy recommendations, based on data that contributes to the promotion of the SDGs, the

question was asked by Professor Margarida Lima Rego: Looking at this data, how do you explain that the 120% growth in health insurance over the last decade, and the current coverage of around a third of the Portuguese population by health insurance, has not been accompanied by a similar rise in the sector's share of responsibility for bearing health costs? How is it that Portuguese families continue to directly bear 29% of their health costs, while the insurance sector only bears 4%? What is failing?

Maria João Sales Luís, CEO of health insurer Multicare, put forward a possible explanation at the round table: in her opinion, these figures show that, for the most part, the insured sum of the policies issued in our country is still very insufficient. The most typical €25,000 insured sum is not nearly enough to cover the occurrence of a serious illness.

For Margarida Lima Rego, there is one core policy recommendation to emerge from this day's conference: the market needs to be sensitized to the importance of health insurance as a tool for financing families' access to the best health care in the event of serious illness, which would be its main social function. Health insurance should not only or primarily be used to pay for consultations, minor surgery, or braces on a child's teeth. It must be able to respond to the most serious health risks as well as regular healthcare expenditures. It is therefore important to ensure that, when deciding how much insurance coverage to take out, that is to say, how high their policy's insured sum should be, people and companies must be provided with the data that they need to understand the practical implications of that decision. How much does it cost, on average, to treat each serious illness? Comparing the average costs with the various cover options available, which is best suited to the protection needs of each household? These are some of the questions that could be addressed in the new Portal.

Policy Recommendation Briefing no. 2

Prof. Maria del Val Bolívar Oñoro

Co-Coordinator

Jean Monnet Module on EU Insurance Law: Challenges in the SDG Era

On the second day of the Conference, the Ph.D. and Master students who composed the panels highlighted the importance of considering some vulnerable populations while configuring insurance products. In particular, they addressed the barriers that are faced while purchasing personal insurance by persons with disabilities, persons with mental health conditions, stigmatized health conditions, or older than 65 years old. Moreover, they highlighted the importance of these products not only for these groups but also for States and society in general.

This was coherent with the conclusions reached by Prof. Christina Ho on the first day of the conference. Particularly when referring that "any society, no matter how high-income, that lacks the infrastructure for managing catastrophic health disasters and covariant risk, is developmentally challenged". Therefore, as Prof. Christina Ho highlighted, there is a need for some sort of "state-sponsored" reinsurance. Especially, when it comes to health.

Therefore, from the discussion that arose during the panels, Prof. Maria del Val Bolivar Oñoro extracts a clear policy recommendation: If States are to be working properly towards achieving the SDGs, State Agents should play an active role in achieving healthcare for all. To that end, bringing together all concerned parties, including private health insurers, is not an option but a need.

This policy recommendation is also coherent with Prof. Abel Veiga's contribution to the conference regarding the Spanish legislation on the topic of euthanasia and assisted suicide and the debate that arose from it. Insurance companies face repercussions in a

variety of manners when various types of legislation are approved. In this case, it should be noted that EU countries are regulating differently the possibility of excluding suicide from coverage. Therefore, not only the States, but also the EU has a great role in bringing together all stakeholders towards achieving the SDGs. In fact, as the fulfilling of certaing SDGs -such as SDG:3- affect Fundamental/Human Rights, these actions should not wait.

To the last end, participants from different insurances companies and associations provided examples of them being compromised to work together to achieve the SDGs as common goals. For instance, Carlos Suares, CEO of Victoria-Seguros, explained the importance of the Chair in Healthy Building.

In sum, the conference showed three points. First, health care coverage for all is an angular piece of the SDG, not only SDG 3. Second, insurance companies play a crucial role in guaranteeing that coverage worldwide and they are growinly aware of that -as Prof. Lima Rego highlighted in her policy recommendations-. And, third and more important, that all stakeholders are willing to work together to achieve that goal.

This Conference forms part of the Jean Monnet Module “EU Insurance Law: Challenges in the SDG Era” (ref. no. 101085125), funded by the European Union (Erasmus+ Programme). This publication is co-financed by national funds from FCT – the Portuguese Foundation for Science and Technology, under project UID/00714/2020.