

**MEDICATION INSURANCE POLICY –
A NEW INSURANCE PRODUCT IN THE POLISH
HEALTH CARE SYSTEM**

Anna Piechota

Department of Insurance
University of Łódź

Key words: medication insurance, healthcare system, health expenditure.

Abstract

In the Polish healthcare system, medications (including compounded preparations) are wholly or partially paid for from public funds. Subsidising medications which are either central or incidental to treatment (e.g., when patients are unable to work because of an illness) means that medication costs make up a large percentage of total health expenditure and are a drain on the patients' purse. Medication insurance (or drug coverage) policies are a relatively new product and are featured in business insurance portfolios of only a handful of insurance companies offering coverage for medication costs. This article sets out to discuss and analyze available medication coverage policies.

**POLISY LEKOWE – PRODUKT UBEZPIECZEŃ GOSPODARCZYCH OBSZARU
OCHRONY ZDROWIA W POLSCE**

Anna Piechota

Katedra Ubezpieczeń
Uniwersytet Łódzki

Słowa kluczowe: polisy lekowe, system ochrony zdrowia, wydatki na ochronę zdrowia.

Abstract

W systemie ochrony zdrowia w Polsce leki (w tym recepturowe) znajdują się w katalogu świadczeń gwarantowanych w całości lub w części finansowanych ze środków publicznych. Konieczność dofinansowania leków, których przyjmowanie może być podstawą bądź uzupełnieniem procesu leczenia (np. w sytuacji niezdolności do pracy wywołanej chorobą), skutkuje wysokim odsetkiem w łącznych wydatkach na ochronę zdrowia oraz uszczupleniem środków finansowych pozostających w dyspozycji pacjenta. Polisy lekowe (in. ubezpieczenia lekowe) są stosunkowo nowym produktem w ubezpieczeniach gospodarczych nielicznych zakładów ubezpieczeniowych oferujących pokrycie kosztów zakupu leków. Celem artykułu jest omówienie oraz analiza dostępnej oferty polis lekowych.

Introduction

Insurers in Poland sell a variety of insurance products, including several types of business insurance, offering medical benefits similar to those available under public health insurance. Drug insurance is one such product, the other examples being supplemental health insurance or hospital coverage.

Medication is a guaranteed benefit in the Polish public healthcare system and topics such as access to drugs, what drugs are reimbursable or how patients pay for drugs are regulated by law. The need to pay for drugs as part of treatment regimens means that costs for medications make up a large percentage of total health expenditure and are a drain on whatever funds the patients have. Patients who struggle financially may even forgo buying drugs entirely. All of this means that the drug expenditure may need to be managed through drug insurance.

Drug insurance (or drug coverage) policies are a relatively new product featured in business insurance portfolios of only a handful of insurance companies offering coverage for drug costs. This type of insurance is voluntary and prospective policyholders should base their buying decisions on an analysis of their needs and the choice of available insurance products.

This article sets out to discuss and analyze the available drug coverage policies.

Medication as a guaranteed benefit in the Polish healthcare system

In Poland, healthcare and its organisational and financial underpinnings are regulated by the Healthcare Benefits (Public Funding) Act of 27 August 2004 (Journal of Laws of 2004, No. 122, item 696, as amended; „the Act”). The Act specifies which healthcare benefits are guaranteed, i.e. which of them are funded publically, and whether they are funded in whole or in part. In addition to the so-called health benefits¹ and ancillary benefits², guaran-

¹ Health benefit: any action aimed to prevent disease or maintain, regain, restore or improve health, and any other medical action resulting from treatment or from other laws regulating provisions of health benefits (point 40).

² Ancillary benefit: accommodation and nutrition, adequate for the patient’s state of health, provided in a hospital or in some other healthcare institution engaged in such curative activities as provision of in-patient or 24-hour health care, transportation services and ambulance services, and also accommodation provided outside a healthcare institution if the need to provide it is determined by specific conditions of a guaranteed benefit (point 38).

ted benefits also include medical benefits in kind which are used to support treatment processes. These are drugs, medical devices, orthopaedic appliances, and ancillaries.

In the Act, drugs (medicines) and medical devices are defined as follows:

- Drug: a medicinal product as defined in the Pharmaceutical Law Act of 6 September 2001 (Journal of Laws of 2008, No. 45, item 271);
- Compounded drug: a medicinal product prepared in a pharmacy based on a doctor's prescription;
- Medical devices: medical devices, devices used for in vitro diagnosis, accessories for medical devices and devices used for in vitro diagnosis, and active implantable devices.

Other than these, guaranteed benefits also include foodstuffs for particular nutritional uses. These benefits are available by prescription and benefit recipients (i.e. anyone covered by health insurance under the social security scheme) can obtain them from pharmacies.

These benefits (including drugs) are reimbursable, which means that all or some of the costs to purchase drugs, foodstuffs for particular nutritional uses and medical devices are paid for by the National Health Fund (NFZ). The rules, conditions and procedures involved in issuing administrative decisions on whether or not drugs, foodstuffs for particular nutritional use and medical devices will be reimbursable are set out in the Reimbursement (Drugs, Foods for Particular Nutritional Use, and Medical Devices) Act of 12 May 2011 (Journal of Laws No. 122, item 696, as amended).

The Reimbursement Act has established separate reimbursement categories for:

- drugs, foodstuffs for particular nutritional use and medical devices subject to prescription;
- drugs, foodstuffs for particular nutritional use, and medical devices used under specific drug schemes;
- drugs used in chemotherapy;
- drugs and foodstuffs for particular nutritional use which are provided as guaranteed benefits other than those specified above.

The reimbursement system covers drugs, foodstuffs for particular nutritional use and medical devices which are subject to prescription and provided to benefit recipients:

- free of charge (B),
- for a lump-sum payment (R),
- for a co-payment at 30% or 50%,

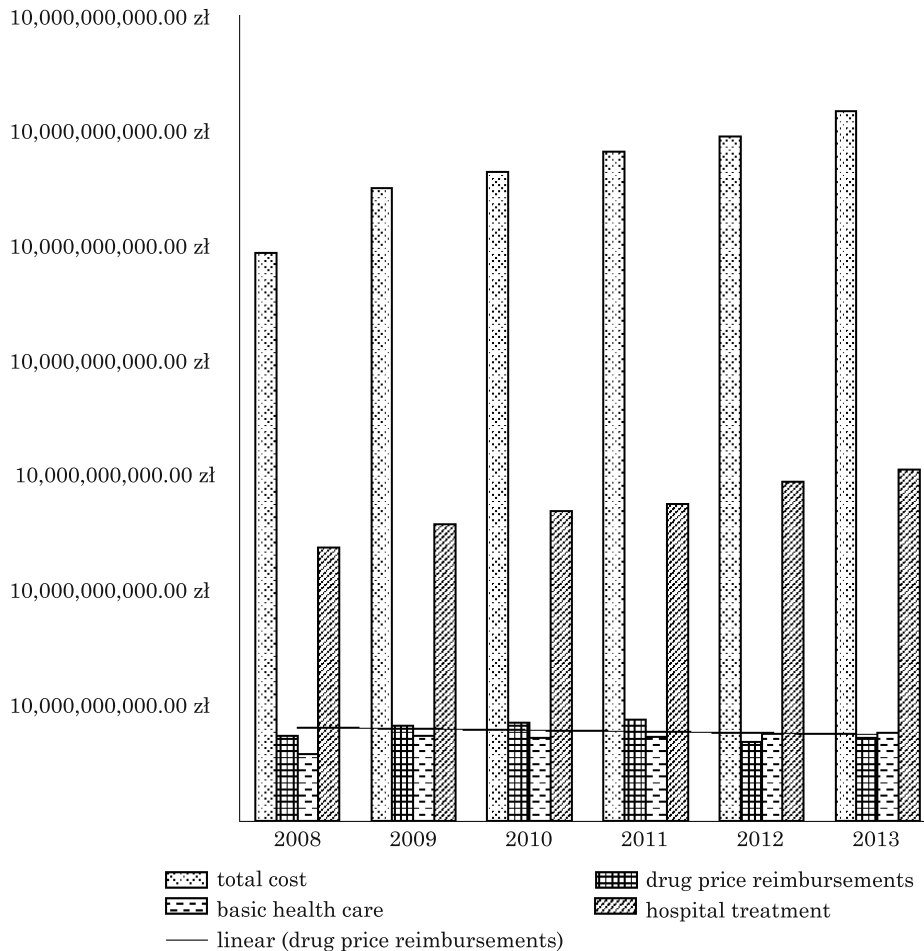


Fig. 1. Healthcare expenditure: total cost, hospital treatment, basic health care, and drug reimbursements for 2008-2013

Source: NFZ aggregate financial statements for 1 Jan 2009 – 31 Dec 2009; NFZ aggregate financial statements for 1 Jan 2011 – 31 Dec 2011 (p. 32); NFZ aggregate financial statements for 1 Jan 2013 – 31 Dec 2013 (p. 36).

up to the funding (reimbursement) limit, with the difference between the NFZ funding limit and the retail price³ to be covered by a patient Article 2.26; Journal of Laws of 2011, No. 122, item 696.

³ Retail price is the regulated price of a drug, a foodstuff for particular nutritional use or a medical device (i.e. their selling price as determined in an administrative reimbursement decision, including VAT) to which the following are then added: a regulated wholesale mark-up (at 5% of regulated selling price) and a regulated retail mark-up (calculated differently on the wholesale price as per statutory algorithms) (Article 7.1–7.4; Journal of Laws of 2011, No. 122, item 696).

Therefore under the existing law, benefit recipients (patients) who buy prescription drugs in a pharmacy pay for the difference between the funding limit for a drug and its retail price.

Drug reimbursements are a major healthcare expenditure item for NFZ, second only to hospital treatment and basic healthcare costs. Between 2008–2013, the average reimbursement figure was PLN 7,838,468,422.03, or 14% of total healthcare expenditure on average (*Łączne sprawozdanie finansowe... 2010, 2012, 2014*). Drug reimbursement levels for 2008–2013 are shown in Figure 1.

Private spending for medicines

Due to their high use, drugs and pharmaceutical products are a significant cost item for the general public in Poland, despite reimbursements from the National Health Fund. For the most part, drug and pharmaceutical product purchases are treatment-related. Increasingly, however, they are also triggered by pharmaceutical marketing campaigns. These are primarily focused on drugs and dietary supplements which are available over the counter and are used for individual treatment, often without supervision from a physician.

Annual spending on drugs (prescription and reimbursable medicines) is approx. PLN 25 billion, around PLN 9.6 billion of which is spent on medicines which do not need to be prescribed by doctors (SUDAK 2014). The figure makes up a substantial percentage of the total pharmaceutical expenditure among the general public. Available figures show differing per-group drug consumption rates and expenditure levels based on socio-economic status.

According to data from the Central Statistics Office (GUS), drugs or dietary supplements are used by over 50 per cent of people in every age group (except 3–6 year-olds). Those who use them most often, however, are old-age or disabled pensioners (93.3%; by source of livelihood); in terms of age, the most frequent users are people aged 60–69 (90%) and 70 or more (96.9%) (Fig. 2) (*Łączne sprawozdanie finansowe... 2014*, p. 109, 110).

This high consumption of pharmaceuticals translates into a high level of drug expenditure in households. According to a 2013 study by GUS, the per-person expenditure for drugs and pharmaceutical products was PLN 36, or 66.7% of average monthly healthcare expenses (*Łączne sprawozdanie finansowe... 2014*, p. 57). The findings of the 2009–2013 Social Diagnosis study (*Diagnoza społeczna*) show that an average of 92% of all households purchase drugs and medical products, the average amount being PLN 357.40 (figures are for one quarter in each surveyed year) (Fig. 3) (CZAPIŃSKI, PANEK 2009, 2013).

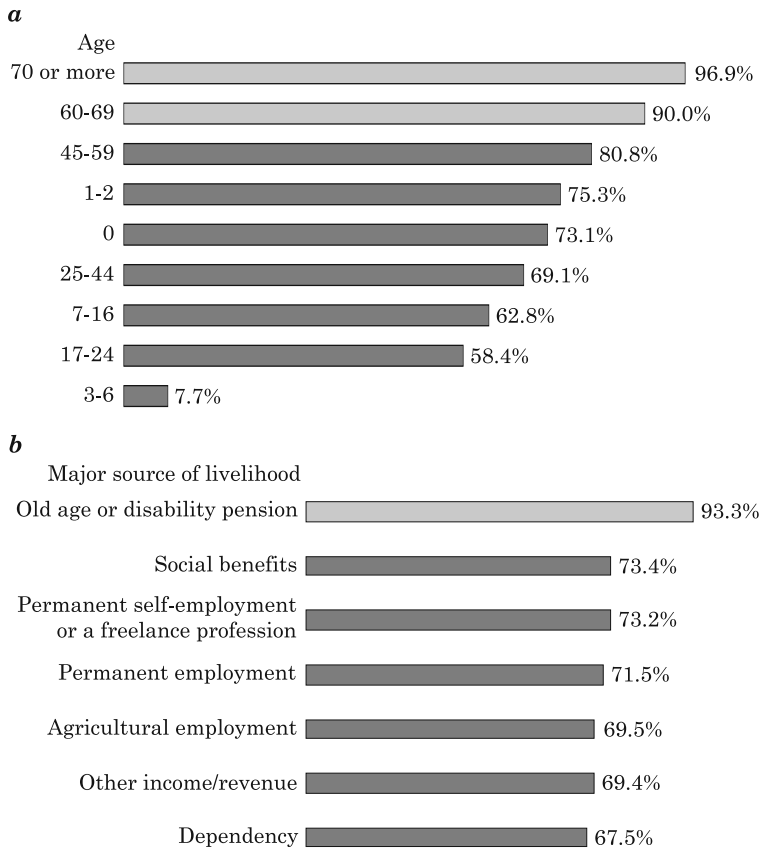


Fig. 2. Percentage of drug or dietary supplement users in 2013 by age and major source of livelihood:
a – age, *b* – major source of livelihood

Source: ŻYRA (2014, p. 109, 110).

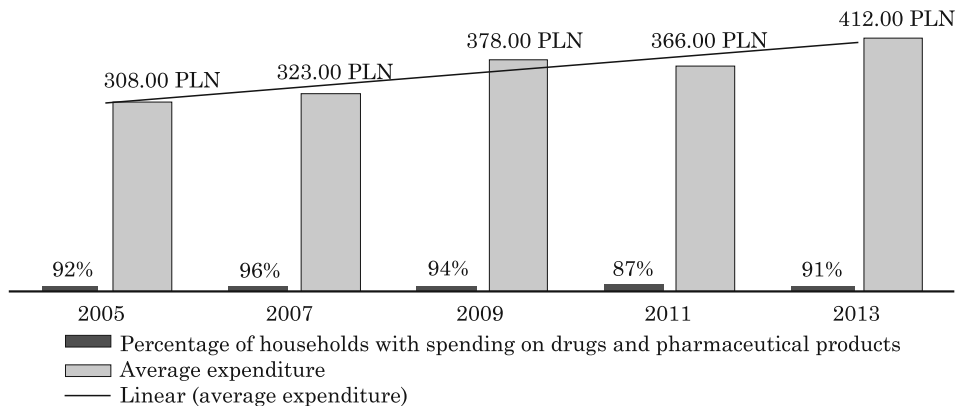


Fig. 3. Percentage of households with quarterly spending on drugs and pharmaceutical products, and the amounts of such expenditures from 2005–2013 (entire samples)

Source: Compiled from CZAPIŃSKI, PANEK (2009, p. 114, 2013, p. 114).

The higher usage of medicines amongst old-age and disabled pensioners translates into their higher health spending, with per-household health expenditure for old-age and disabled pensioners accounting for 8.3% and 7.6% of total household budgets, respectively (*Łączne sprawozdanie finansowe...* 2015, p. 162). Between 2009–2013, quarterly drug and pharmaceutical product spending in old-age and disabled pensioner households was PLN 414.20 and 376.60, respectively (Figure 4) (CZAPIŃSKI, PANEK 2006, 2007, 2009, 2013).

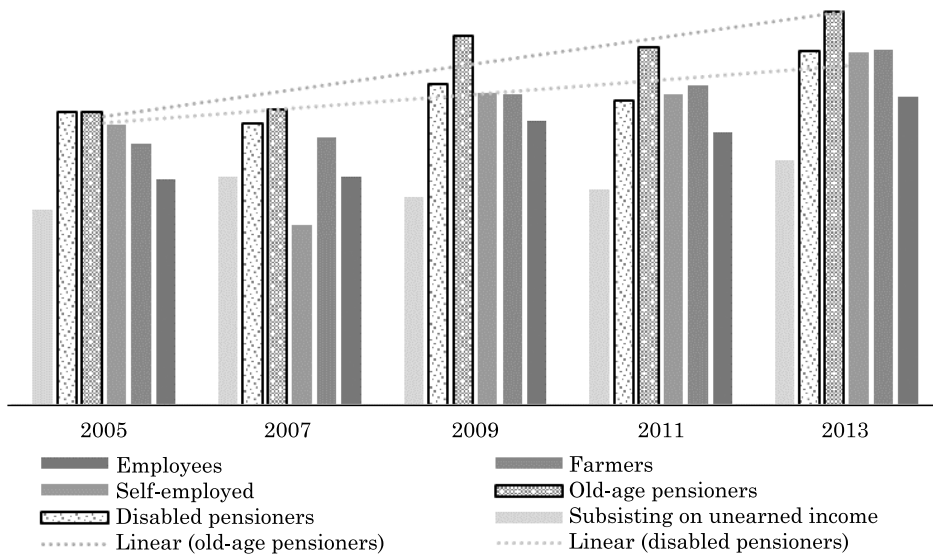


Fig. 4. Household spending on drugs and pharmaceutical products per socio-economic group (whole samples) in 2005, 2007, 2009, 2011 and 2013 (data for 3 months)

Source: CZAPIŃSKI, PANEK (2006, p. 194, 2007, p. 103, 2009, p. 113, 2013, p. 115).

Higher co-payments, at 40% on average (ŁANDA 2015), and low incomes mean that some households forgo purchasing drugs altogether, even when drugs are needed or a cheaper alternative is offered. Households which do this most often are those of disabled pensioners (39.8%), people subsisting on unearned income (45.1%), and old-age pensioners (21.0%). (CZAPIŃSKI, PANEK 2013, p. 111, 113).

Medication coverage products offered by insurers: an analysis

One could assume that a contributing factor to insurance companies devising and offering medication coverage plans (including drug insurance policies) was the new reimbursement system introduced by NFZ, in that it

brought regulated prices for medicines. That and the fact that patients must pay for the cost of medications out of their pockets, in whole or in part, all translate into high drug-related expenditure levels.

Medication insurance is related to and supplements what is available via the public system. The link between the two (especially with regard to drug reimbursement) is that the former only applies to „*prescription drugs available from pharmacies*”. Even though drug coverage is currently available from a handful of insurers only, the products offered are quite different⁴.

The insurance benefit in the first form of available medication coverage is the percentage of co-payment⁵ for prescription drugs (or drug alternatives) included in the list of drugs covered by the insurer. Since the benefit is available for prescription medications, the insurer will finance part of a drug payment covered by the patient. The benefit may be realised in an affiliated pharmacy which accepts the insured's medication card or in any other pharmacy. Where the benefit is realised in an affiliated pharmacy, the following are needed: a medical prescription and what is called a medication (or insurance) card which a policyholder receives when executing his or her insurance contract. Otherwise, the insured will be reimbursed for the cost a drug based on a medical prescription and a proof of drug purchase (such reimbursement to the extent of the insurer's co-payment percentage). The level of medication co-payment by the insurer is limited to the sum insured, as specified in the contract. This type of coverage is offered as group or individual insurance under a separate insurance contract or as an addition to life insurance. In group insurance, the contractual parties are the insurer (insurance company), the policyholder (employer) and the insured (employee). In this type of insurance, the insurer and the policyholder agree on a co-payment percentage, a sum insured and a minimum number of employees which must take out insurance. In individual insurance, the contractual parties are the insurer (insurance company) and the insured. The insurance premium will depend on the sum insured, medications covered, a co-payment percentage, and (for group insurance) a proportion of all employees to those who take out the insurance. The insurance premium may be paid entirely by the policyholder or by the insured, or partly by both the policyholder and the insured. Insurance is available to anyone aged 69 or less; however, the liability of the insurance company ends in the calendar year in which the insured turns 70. If agreed to by the insurer, coverage may be extended to the insured's life partner or child (in group insurance, an agreement will also be needed from the policyholder (employer)). In such a case, the terms of insurance applicable to

⁴ Information on drug insurance is derived from publically available source documents on insurers' websites.

⁵ A specific percentage of the insurer's share in payment for a drug.

the insured will also apply to others who are co-insured (sum insured, insurance premium, percentage co-payment) (MAKOWIECKI 2012, ROSIK 20120.

The insurance benefit in the second form of available medication coverage is a percentage or amount of retail price (subject to limits specified for each drug pack covered by the selected insurance option). Additionally, the calculation of the insured's benefit depends on whether or not a drug is reimbursable. For reimbursable medications, the cost to be refunded to the insured is the difference between the drug's retail price and the reimbursement limit as determined by the Health Minister and is applicable on the day the prescription is processed. For non-reimbursable drugs, the refund is a percentage of the retail price as specified for any given medication. As with the first form of coverage, here too, the insured uses his or her medication card to buy medication in an affiliated or unaffiliated pharmacy. The insured may be a person aged 75 or less, and the contract of insurance may extend to the insured's partner or children. Insurance is taken out based on an application which sets out the applicant's personal particulars, the option selected, the terms of insurance, and information on the applicant's health and lifestyle. Two options are available (I & II), each providing for a different range of covered medications. Option II also provides for a four-month waiting period in which the insured is not eligible for any cash benefit with respect to the costs incurred in the purchase of prescription medications. The waiting period is not applicable to renewed coverage. The premium depends on the insured's risk assessment which includes such factors as the insured's health, lifestyle or occupation. The product comes with the insurer's liability exclusions, which set out circumstances in which the policyholder will not be refunded the cost of medications. These relate to drug purchases in connection with health treatment resulting from the introduction and existence of any state of emergency, martial law, war or acts of war, or from the consumption of alcohol, narcotic drugs or addictive substances. The exclusion also covers purchases of medications in connection with health treatment where the symptoms had been present or treated before the insurance contract was made, and such symptoms were either not reported or they were reported falsely. A further liability exclusion is that the insurer will not provide any refunds for medications that are not on the list of medications covered by the insurer.

When compared, both forms of medication coverage offer sharing in the insured's medication costs as their insurance benefit. The difference is in how they define sharing. The first product specifies it as a percentage of price for all covered medications; the second one offers a percentage of price or a specific amount for each drug pack covered by insurance. These different mechanisms for calculating the insurer's share of costs mean that the two

offers are not comparable as they define their key parameters (co-payment share and limits) differently.

It seems that whether an offer is attractive to the client (the insured) will depend on a number of insurance parameters, such as:

- the sum insured: this is the insurer's co-payment limit and the higher it is, the more benefit the insured will receive (in group insurance, this parameter is agreed without the involvement of the insured and the co-insured);
- the co-payment percentage or amount: this is the portion of a drug price the insurer will pay for. From the client's point of view, it should be as high as possible (here too, this parameter is agreed without the involvement of the insured and co-insured in group insurance);
- the insurance premium: this is because it reflects the insured's liability for the coverage he or she will be receiving. From the client's point of view, the premium should be at the lowest acceptable level. In individual insurance, however, the premium will be variously affected by the insured's risk assessment (most often, this means that an increase should be expected), the sum insured, and the percentage or amount of the insurer's co-payment for the cost of medicine.

The element that diminishes the attractiveness of insurance products are their liability exclusions, especially those with a policy that no refunds are offered for medications bought to treat symptoms that occurred or were treated before the insurance contract is made.

Concluding remarks

Medication is a guaranteed benefit in the Polish public healthcare system. As such, medications are wholly or partially paid for from public funds. Despite the reimbursement system, Poles continue to incur significant expenditure on prescription medications (KALBARCZYK 2015).

Drug coverage which the insurers offer as a way to cover some medication expenses is an interesting option, especially after key (economic) data have been obtained from the insurer concerned, such as the sum insured, the insurer's co-payment level, and the insurance premium that reflects the personal circumstances of the insured (such as his or her age, health, or occupation). If all the required circumstances are in place (employment), the client may choose either a group or an individual plan.

It should be noted that the availability of medication coverage is restricted in that it is subject to age limits: the prospective insured must not be older than 69–75 years of age. Data show that the highest medication use and medication expenditure is among people aged 60–69 or 70 and older, and among those

subsisting on old-age or disabled pensions. Therefore, the target group that could benefit the most from drug insurance is excluded from coverage. Furthermore, given that insurers base their premium calculation on individual risk assessments, an assumption must be made that the premium will be beyond the means of those socio-economic groups.

The insurance premium is another limitation. Data on medication spending levels, low income among numerous social groups and the fact that some patients forgo medication for cost reasons might indicate a lack of financial wherewithal to pay the insurer for the coverage provided. It seems, however, that this limitation could be overcome if a stipulation is provided (as present in one of the group insurance offers) that premiums can be paid by the policyholder (i.e. the employer).

The development of medication insurance policies will provide patients with an opportunity to cut down on their medication costs. As with other types of insurance, whether or not a suitable policy is chosen will depend on the knowledge and understanding of the insured's needs and on the terms of the insurer's offer. It is difficult to assess whether (and for whom) taking out medication insurance is economically reasonable (where such factors as the need for medication, income level, or drug spending level are taken into account) unless key (financial) parameters of coverage are known. It seems that further analyses of medication insurance offers could be a step towards achieving that goal.

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