

PRIVATE HEALTH INSURANCE PRODUCT – POLISH EXPERIENCE IN COMPARISON TO THE EUROPEAN STATE OF AFFAIRS

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—Abstract —

Private health insurance in Poland is deemed to be a potential driving force for the development of the whole insurance market. Currently, private health insurance is a diverse collection of insurance products in terms of their structure. The purpose of the paper is to reconstruct - on the basis of general terms and conditions of insurance – and to present the standard health coverage offered by domestic insurers. Greatest attention will be turned to the following policy conditions: people insured, insurance period, types of guaranteed benefits (core and additional), territorial scope of insurance and insurer's liability limitations. In this context, the author also attempts to mention the changes in policy conditions that were observed on the Polish health insurance market in years 2005-2011 as well as the essential problems existing on it. As far as possible, Polish experience in private health insurance product design will be compared with European state of affairs.

Key Words: *private health insurance, Polish insurance market, health insurance product design*

JEL Classification: I13, G22

1. INTRODUCTION

Similarly to other European countries, health care in Poland is financed from mixed, private and public sources. Since 1999, when the Law on Universal Health Insurance of 6th Feb 1997 came into effect, health insurance contributions have been the dominant source of public finance, paid now to the National Health Fund. Additionally, public funds are derived from the state budget and local self-government budgets. Owing to dual nature of public sources, the Polish system is defined as an insurance-budgetary system. (Kuszeowski and Gericke,2005:21)

Private sources account for 27.8% of Polish total expenditure on health care (OECD,2010). Therefore Poland can be put in the group of states with relatively high level of private resources spent on health care. Out-of-pocket payments made when using medical services are the main source of generating private resources, whereas private health insurance plays a marginal fiscal role in our country. (OECD,2012:49-50,64) Aside private health insurance, however, there are pre-paid schemes in the form of so-called “medical subscriptions”. „Medical subscriptions” are offered by specific providers („subscription-based health providers” (see Thomson and Mossialos,2009:38)), which do not operate under the insurance law. Therefore “medical subscriptions” are also called “quasi insurance” and follow the American example of Health Maintenance Organizations (HMOs), where financing is integrated with health services provision. Together, private health insurance and medical subscriptions account for approximately PLN 2 billion¹ out of about PLN 99 billion of total expenditure on health. (OECD 2012:64) Polish insurance market representatives’ estimates indicate that the volume of gross written premium within the private health insurance does not exceed PLN 200m annually². (Gorajek,2011:495)

Small importance of private health insurance as it is assessed through the prism of premium volume does not automatically mean stagnation in terms of insurance product construction. As the Polish health care system is sought to be reformed, the subject of private health insurance has become rather popular. Ever more

¹ 1 PLN ≈ 0,25€

² By contrast, in 2010 total gross written premiums from life and non-life insurance amounted to 54 billion PLN. (KNF,2011:Table I.2)

innovative plans of systemic implementation of private health insurance have been devised by various institutions' experts, including governmental ones. Some of these plans have been even written down in the form of parliamentary bills. This causes private health insurance to be perceived as a potential driving force behind development of the Polish insurance market. This, in turn, makes it an effective catalyst of change in the products available on the market.

2. PRIVATE HEALTH INSURANCE PROVIDED BY POLISH INSURANCE COMPANIES

2.1. Providers' ambiguous offer

There is a certain degree of chaos within the range of products which guarantee a pre-paid access to medical care. Firstly, it is the already mentioned simultaneous existence of private health insurance along with medical subscription. Secondly, insurance products linked to health (sickness) are both offered by life and non-life insurers. Finally, the notion of private health insurance does not appear either in business insurance law or in the official insurance market statistics published by Polish Financial Supervision Authority (KNF). We do find there, however, data with reference to accident and sickness insurance if supplemental to the main kind of life insurance as well as data on accident insurance and sickness insurance within the non-life insurance branch. The sum total of gross written premium for this kind of products amounted to almost PLN 6 billion in 2010 (KNF,2011a: TableV.1,V.2). It must be remembered that the categories of accident insurance and sickness insurance also encompass the popular in Poland critical illness insurance, damage to health insurance, disability insurance, daily hospital allowance insurance or travel sickness insurance. The above types of insurance are not relevant to financing health care. They merely guarantee flat rate payments not related to the real cost of treatment or cover the cost of emergency treatment occurring on a tourist trip. Ultimately, it is products generally denoted as comprehensive medical expense insurance that ensure financing the access to health care. Further considerations focus only on such private health insurance, the fiscal relevance of which in Poland is very slight at present.

Insurance business is conducted by 60 insurers in Poland (28 life insurers and 32 non-life ones). In 2011 16 companies offered private health insurance (8 life

insurers and 8 non-life ones)³. The contrast between the number of providers and the amount of the gross written premium proves that ‘the number of insurers is not indicative of the market size’ (Thomson and Mossialos, 2009:37). In many European countries mutual associations play a significant role in the private health insurance market. In Poland, private health insurance is not offered by any mutual association, only by commercial insurers.

As regards providers of private health insurance, there have been two qualitative changes in the last two years which are worth recognising. Firstly, in June 2010 the first provider to offer health insurance exclusively appeared on the market. There are no legal norms in Poland which would enforce specialisation of health insurers, so any specialisation is indeed voluntary. Before 2010 domestic providers had specialised in what was then called “health business”, which was prioritised in their overall strategy (e.g. Allianz Życie, Signal Iduna, Inter Polska or PZU Życie), instead of creating specialist insurance companies. Secondly, two biggest subscription-based companies (Medicover and Luxmed) decided to start insurance activity parallel to subscription. It was formally done through Swedish insurance companies which formally announced the onset of operations on Polish market based on single licence principle.

2.2. Types of guaranteed benefits

In most cases private health insurance benefits are provided in kind, through direct provision of health services. In Poland it is prohibited to join insurance activity and any other activity unrelated directly to insurance. Therefore it is impossible for insurance companies to set up coordinate medical service units (Health Maintenance Organizations). Consequently, insurers sign contracts with medical benefits providers from whom the insured may receive the guaranteed medical benefits. Insurers, like in most EU member states, are allowed to contract providers on a selective basis (they do not have to contract with all providers). The easiest thing then, often done by insurers in Poland, is to contract a selected subscription-based company to provide medical benefits. Owing to that, insurers can access a network of suppliers consolidated by the medical company on the

³ In contrast, there are app. 200 subscription-based health providers (Thomson and Mossialos, 2009:38), many of them operating only locally. The subscription market is concentrated within the three biggest providers (Medicover, Luxmed, Enelmed).

basis of a single contract. Another model, more advanced and less frequently encountered, consists in the insurer (or a third party administration company) establishing their own network of contracted companies.

Few insurers offer a financial benefit consisting in reimbursement of medical care expenses on the basis of invoices submitted by the insurance holder. The insurer always reimburses the cost within the price limit of a single medical benefit assumed in the insurance contract. Such product construction guarantees an entirely free choice of the medical benefit provider, which is not limited to the insurer's contracted companies. At the same time, however, it means "freezing" the policy holder's financial means. From the client's angle the best solution is to combine both in-kind benefits and financial ones within one product (as in Inter Polska, Signal Iduna).

A significant majority of products is multi-optional, where each option is *ex ante* defined by the insurance company. What remains to be done, then, is the choice of one of the combinations by the insurance taker. Between 2005 and 2010 an increase in the average number of options in particular product was noticed. (Holly and Szczepaniak, 2011:115, Table I). At present, more than seven options are offered only for group insurance. In the case of individual products the number of options fluctuates between three and five (Author's own study).

Private insurance of treatment expenses focuses on outpatients' clinic benefits. In fact, all insurers guarantee physician's, paediatrician's or general practitioner's consultation as well as specialists' opinions, laboratory and functional diagnostics as well as medical imaging. As a rule, the offer is also enriched with preventive vaccinations and minor treatment in outpatients' clinic which can be carried out by nursing personnel. Particular products (and their options) vary in terms of number of medical consultants accessible to the insurance holder and the range of diagnostic procedures financed by the insurer. In most cases approximately fifteen specialisations are available, which always include general surgery, urology, dermatology, gynaecology, laryngology, ophthalmology and cardiology. Usually available specialisations include pulmonology, rheumatology, neurology, allergology, oncology, orthopaedics or nephrology. (Osak, 2011:36) The principle is that the access to those consultants is quantitatively unlimited. In the case of

group insurance the core element of insurance cover is occupational health care benefits.

A common element of private health care insurance is medical assistance and an access to a medical hotline.

The most important innovation in the product range after 2005 was commercialisation of products which guaranteed financing of hospital benefits. In the case of in kind benefits the insurance coverage is built in three components: (1) raised standard of the conditions of a hospital stay (e.g. a single or double room, 24-h nursing care, medical consultant's care, the right to select the leading doctor), (2) financing the costs of specifically enumerated surgical procedures carried out within 30 days of notification, (3) financing diagnostic hospitalisation. The latter area of hospital insurance was created in 2011, owing to the only specialised insurer (Medica Polska). In the case of hospital insurance, it is the insurer who selects the hospital. Financing a scheduled hospital stay is hedged with the requirement of a referral to hospital and obtaining the insurer's consent to the treatment (so called pretreatment review).

At present, insurers' liability remains to be extended into the area of covering the costs of preventive dentistry, one day surgeries and rehabilitation treatment. There is a notable extension of insurance products to an annual health assessment report. At the moment, domestic insurers do not engage generally in insurance of expenses on medicines. From the insurer's point of view it is a well-grounded approach, as out-of-pocket health care expenses of Polish households are indeed mainly expenses on medicines.

2. 3. Policy conditions

Domestic insurers like insurers in many European countries set a maximum age limit for purchasing private health insurance. In Europe it is usually set between 60 and 75 years of age. (Thomson and Mossialos,2009:41) In Poland the age criterion falls between the ages of 55-65. Additionally, it is a rule in Poland that insurance protection cannot last longer than until the 65th birthday of the insured. Automatic lapse of the insurance policy takes place on the nearest policy

anniversary after this date. As it can be easily noticed, the upper age limit in private health insurance in Poland is not compatible with demographic trends.

At present, the range of private insurance in Poland consists of short-term products (for one year). The available length of insurance period does not differ from the EU standards. (see Thompson and Mossialos,2009:41) Insurance premiums are established every year, for each consecutive year of the contract validity. The insurance taker can automatically renew the contract every year on a standard basis, if neither party declares to resign from continuation of the policy. Thanks to automatic renewal the insured “avoids” the procedures preceding the conclusion of the contract. However, the automatic renewal clause does not guarantee maintaining the terms of the contract (especially the premium) and its interminability. It is impossible to expect commercialisation of long-term products at the moment (including lifelong ones). Nevertheless, there are first signs of change on the market concerning the length of insurance period. In the second half of 2011 a product appeared in which the insurer guarantees a three-year insurance period, including the unchanged amount of premium and the coverage of benefits.

The basic tool which enables limiting the insurer’s liability is the register of guaranteed health benefits. Therefore the insurer finances only the costs of the registered health benefits, which are required in the insurance period due to a sickness or an accident, or, if the contract determines so, pregnancy and childbirth. Moreover, health benefits are only guaranteed on Polish territory.

As a rule, the cost of benefits resulting from the so called pre-existing conditions is not covered. Waiting periods are not so popular as in other European countries, where they range from one month to a year for most forms of health care (Thomson and Mossialos,2009:46). In Poland the waiting period is always connected with health benefits relating to pregnancy and childbirth, where it is correlated to the length of physiological pregnancy. Besides, waiting period always occurs with scheduled hospital benefits (including one-day surgery) and is encompassed within 3-4 months.

Private health insurance is an open cover product. Insurers do not limit the total value of the “consumed” medical benefits. Insurance companies do not usually

cover the costs of medical benefits resulting from the insured not following the doctor's instructions, committing a crime or attempting to do so, attempted suicide, deliberate health breakdown, infection with HIV virus (developing AIDS), substance intoxication, medical experiments, sex-change operation, infertility or military operations. In this respect the Polish solutions correspond to the European experiences. When it comes to cost sharing and no claims bonuses, however, the situation is quite different. Cost sharing is only occasionally used in Polish products, while no claims bonuses have not been applied at all so far.

3. CONCLUSION

Private health insurance in Poland is currently functioning as supplementary insurance. This is caused directly by the regulations referring to the functioning of health security system. The current state of affairs, along with marginal premium income from private health insurance makes one very mildly optimistic as for the significant transformation prospects for this sector of Polish insurance market. Also, the chance to intensify the changes was squandered when the Ministry of Health abandoned a bill which offered a tax relief to individuals purchasing private health insurance. The most probable scenario for private health insurance in Poland now is further quantitative development on the side of providers. As regards the product structure transformation, the same evolutionary (step by step) direction and pace of change should be expected. One might become slightly more hopeful when looking at recently intensified health products distribution within the bancassurance co-operation. At present, it would be definitely premature to expect e.g. expansion of territorial limits of health benefits to the ones provided by suppliers beyond Poland or creation of long-term products. It is still possible, however, to point at some areas for product enhancement which would be less costly for insurers. The sphere of health promotion benefits is another area worth interest. Also, a lot can be done as regards comprehensible edition of general terms of insurance content as well as transparent (allowing comparisons with rival companies' offer) presentation of guaranteed health benefits registers.

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