# Limited Insurance Policies Expected to Grow

BY JOYCE FRIEDEN
*Associate Editor, Practice Trends*

WASHINGTON — Expect more health plans to offer limited insurance policies for people who are currently uninsured, Robert Laszewski said at a press briefing sponsored by the Center for Studying Health System Change.

"Insurers are recognizing that the 45 million people who are uninsured are a market," said Mr. Laszewski, founder and president of Health Policy and Strategy Associates, a consulting firm. "Now, they're not a market for comprehensive major medical insurance, but they are a market for very limited benefits programs, programs that cost perhaps $50-$100 per month."

He added that such plans—which typically include a wellness checkup every other year, a few visits to a primary care physician, and a drug benefit based on generic drugs—have come under criticism for not doing enough to help the uninsured. "I think that's a false set of arguments," he said. "Of course they're not going to solve the problems of the uninsured, but [they] do respond to the needs of people who cannot afford health insurance."

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Most speakers at the conference also were upbeat about the future of consumer-driven health plans, such as health savings accounts (HSAs), although Christine Arnold, an executive director specializing in managed care at New York brokerage firm Morgan Stanley, noted that such plans are still a very small part of employers' health insurance offerings.

"Less than 5% of any HMO's total book of business is right now in any form of consumer-directed health care," she said. "We may be on the cusp of a product revolution, which I've been hoping for, but I don't think it's here yet."

Mr. Laszewski added that although consumer-driven health care "is a wonderful thing," it focuses on first-dollar benefits rather than on the real problem in health care spending: that 75% of the costs are incurred by the 15% of people who are very ill. "It's the sick people who blow through the deductibles and get to the out-of-pocket maximums," he said. "Sick people are the ones who control costs."

"When the day is done, the incentives haven't fundamentally changed. In about another year or two, we're going to get this out of our system," he continued.

Efforts to measure physician quality also came in for much discussion. "While I think 'sabotage' is a strong word, I would say there has been resistance by the health plans because each of them is trying to use this initiative as a competitive advantage," said Ms. Arnold. "The tug of war is that employers want this on a macro basis—they want a Consumer Reports for providers."

Two new initiatives could help consumers and employers compare health care quality, Ms. Arnold said. One is the Ambulatory Care Quality Alliance, a project of the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality. "They are trying to put together an objective list of measures. How do we measure who is a good provider? As we think about ways to assess quality, I think we need a standard."

The second initiative involves a group of employers and consultants who are exploring "care-focused purchasing"—that is, getting health plans to aggregate their provider data so that employers and consumers can see which are the highest quality providers. "Any one health plan can't give you a full picture of [a physician]," she said. "This is an effort by employers to get together to pull providers and health plans in."

Frederic Martucci, a managing director specializing in not-for-profit companies at Fitch Ratings, a New York credit-rating firm, said Medicare's efforts to measure provider quality will likely impact the health care market. "It's only a little bit, but the camel's nose is in the tent, and as long as Medicare is interested in rewarding providers—especially hospitals—[that exhibit] quality, I think other people are going to jump on the bandwagon." ■