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Preliminary Report on a Secure Benefit Set for the Public Employees Insurance Program (PEIP)

Executive Summary

December 15, 2005
Minnesota Department of Employee Relations

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I. Introduction and Context

The Problem

Already high and rising health care costs are making health coverage unaffordable for many and eroding employer-based health insurance. Employers, especially smaller firms, may be dropping health insurance for employees, scaling back on the coverage available, and/or requiring that employees pay more. Increasing health care costs, reflected in higher monthly insurance premiums and out-of-pocket payments when services are provided, are also significant issues for the self-employed and others without access to employer-based coverage.

The design of most traditional third party health insurance can be a factor in the costs and erosion of current health coverage. Despite a recent proliferation of new product offerings, most health insurance is still quite comprehensive, often presenting employers and individuals with only an "all or nothing" choice: either to purchase expensive insurance products covering a wide array of medical services, often with relatively modest direct consumer payments, or to receive nothing – no health coverage.

In response to concerns about rising health insurance costs, and to address the "all or nothing" conundrum of existing insurance options, a number of efforts are underway to develop and market lower cost health benefits and products. Major employers such as Wal-Mart, and a coalition of over 50 large employers known as the "HR (Human Resources) Policy Association," have attracted recent national attention with news that they will be offering new types of health packages for employees, specifically in attempts to provide lower cost alternatives to conventional employer-sponsored health coverage. Major insurers and health plans such as UnitedHealth Group and Aetna have announced new products with lower monthly premiums. Many states and other organizations are also examining new health coverage products and offerings.

Purpose and scope of this report

This report is a preliminary exploration of the concept of a "secure benefit set" to help address the issues above. It is being undertaken as part of requirements and authorizations of Minnesota Session Laws 2005, Chapter 156, Section 47, which require the Commissioner of the Minnesota Department of Employee Relations (DOER), in consultation with other state agencies, to report to the Minnesota Legislature on the creation of a "Health Care Purchasing Authority" (HCPA) responsible for "all state purchasing of health care." A report has been submitted under separate cover for review and consideration by the Legislature describing several options for the creation of an HCPA, and to contribute to additional dialog on the topic of a Health Care Purchasing Authority and related health care reform.

The HCPA study legislation includes several provisions related to the design and availability of a "secure benefit set", including:

- Authorization for the DOER commissioner to make available a secure benefit set to public sector employers through an existing voluntary health insurance pooling arrangement administered by DOER, known as the Public Employees Insurance Program (PEIP)[1].
- Three other HCPA-specific provisions, including:
    - That the HCPA "convene a panel of health care policy experts and health care providers, to establish a process to select evidence-based guidelines ... and implement an integrated approach using these guideline for purchasing decisions and coverage designs;"
    - That it define a "secure benefit set" providing coverage for preventive care, prescription drugs, and catastrophic coverage that also takes into account the needs of special populations, including persons who are elderly or disabled and persons with chronic conditions; and
    - That it prepare a report and plan for public employers, nursing homes and other long term care providers, and individuals to purchase the secure benefit set through the HCPA.

DOER is exploring the secure benefit set concept for PEIP and is submitting this preliminary report as part of that exploration and planning process. It is hoped that this information will also facilitate discussion of the secure benefit concept as part of the broader legislative consideration of the Health Care Purchasing Authority.

The secure benefit set is not further described in the HCPA legislation. However, the current context for this issue suggests interest in a benefit set that is "secure" both in the sense of being less costly, while at the same time providing access to needed care and financial protection. While such a benefit set could possibly take many forms, there are a variety of converging interests in the design and availability of:

- "Basic" health benefits that are less costly than most typical benefit designs currently being offered;
- Benefits that provide individuals with protection from financial catastrophe due to high medical expenses; and
- Benefits that provide access to needed medical services and health care proven to be effective to maintain and improve health.

II. Study Methods

As part of its planning to offer a secure benefit set through the Public Employees Insurance Program (PEIP), DOER:

- Reviewed other relevant reports, studies, and private and public sector examples of new and emerging health benefit designs;
- Met with state agency staff and the Health Care Guidelines Workgroup, an interdisciplinary workgroup of health policy experts and health care providers that advised the Minnesota

[1] The Public Employees Insurance Program (PEIP) is a voluntary statewide health-dental-life insurance pool authorized by Minnesota Statutes § 43A.316 that has been in operation since the late 1980s. The program provides Minnesota's public employers, including counties, cities, townships, and school districts, with the option to purchase a package of benefits for their employees and retirees, and their dependents. Individually tailored health plans allow each employer group to choose the amount of deductibles and coverage levels paid. Employee eligibility and employer contributions are determined by each employer group, most often through collective bargaining. PEIP currently serves 102 total public employer groups and approximately 2,085 enrolled employees.

Department of Health in 2004 and 2005 on how best to encourage the use of evidence-based guidelines by providers and consumers. The Health Care Guidelines Workgroup submitted a report on the topic, "Recommendations on Systems Improvements to Advance Evidence-Based Health Care" to the Legislature in January, 2005.

- Worked with DOER's consulting actuaries, Deloitte Consulting LLP, in reviewing the secure benefit set concept and examples of alternative benefits designs for PEIP, and in preliminary modeling and pricing of a continuum of example design options.

III. Current Health Benefits Costs

A useful starting point in discussions of a secure benefit set is current health care coverage and costs. Information on current average employer-based health insurance premiums is provided in the table below, based on the results of an annual, large, national survey of employer health benefits by the Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET).[2]

2005 Kaiser/HRET Survey:
Average employer-based health insurance premiums

Type of Coverage	Average 2005 Monthly Total Health Insurance Premium Rates*	Average 2005 Annual Total Health Insurance Premium Rates*
Single (employee only)	$314 to $346 per month	$3,767 to $4,150 per year
Family	$833 to $924 per month,	$9,979 to $11,090 per year

(*average premium costs vary by type of plan: e.g., conventional, HMO,PPO, POS.)

At these costs, medical benefits are generally comprehensive with coverage for at least most major categories of services such as preventive care, inpatient hospital and outpatient care, doctor's office visits, lab, radiology, and other services. Patients and families have out-of-pocket maximums that limit their out-of-pocket exposure, and unlimited or very high annual limits on the total benefits that will be provided. However, the average total annual premium costs cited above for employer-based family health coverage are now more than the annual earnings of individuals working full-time at minimum wage, and are more than many persons' mortgage, car, education, or other traditional major payments.

Because employers typically contribute to premium costs, however, the employee portion of monthly premium costs is much lower than the total cost. According to the 2005 Kaiser/HRET survey, the average employee share of single monthly premiums is $51 per month, and $226 per month for family coverage. Although the dollar amount contributed by employees has risen substantially in the last few years, employee contributions as a share of the total premium have been stable at 16% and 26% for single and family coverage, respectively.

Employers typically offer health benefits designs that generally require some forms of cost sharing at the point services are delivered. The Kaiser/HRET survey report indicates that the average point-of-service cost share for employees in 2005 is $323 for annual first dollar

[2] A description of the survey and its results is available online at http://www.kff.org/insurance/7315/index.cfm.

deductibles, with $15 to $20 copays per doctor office visit, and $10 to $35 copays for each prescription drug.

While the average out-of-pocket costs faced by covered individuals are typically much lower than the actual cost of services, or the portion paid by their employer, they can be significant for lower income individuals and/or persons with high or persistent medical expenses. In addition, the cost sharing requirements for some consumers may be much more than the average. However, the averages above also indicate the level at which individuals are generally required to pay directly out-of-pocket, which may be instructive in considerations of price points that individuals or employers may consider acceptable under alternative health insurance product designs and pricing.

IV. Benefit Design Issues

While there are many efforts underway to develop and introduce health insurance options other than the current "all or nothing" standard of coverage, the solution is difficult, complex, and elusive. A combination of health benefits meeting broad, sometimes varying definitions of affordability, personal financial protection, health needs and value is strikingly difficult to achieve. In practice, there are many issues and trade-offs to consider, including:

- There are often no agreed-upon definitions of terms such as "catastrophic" or "affordable", which can also vary greatly depending on individual situations. In addition, "preventive" and "catastrophic" coverage represent important ends of the health care spectrum, but do not address important components in the middle of the spectrum that can result in significant costs and greatly affect health outcomes.

- The challenge of achieving more affordable, attractive health benefit designs is further confounded by the fact that a relatively small number of persons will have high medical expenses in a given period, while most will have few or possibly even none. This so-called "80-20" rule, in which roughly 20% of an insured population accounts for 80% of its costs, often makes it even more difficult to find a single insurance design that will meet the needs of all. Some persons will value preventive and primary care services intended to maintain generally healthy people in reasonable health, while others with serious illness or chronic conditions will value access to a wide array of state of the art services and care. Health status is also not static, and changes over time, as do employment and incomes, assets and accumulated wealth, and family status.

- Excluding or limiting coverage, or increasing the share of costs borne by consumers, can lower monthly premium costs but may come at a price to many individuals and payers, and the health care system.
    - Benefit costs and exclusions or limitations may result in needed care not being accessed when it is timely and most cost-effective, resulting in higher subsequent health care costs. Less comprehensive insurance packages may not provide desired levels of protection to avoid financial catastrophe due to severe illness or injury.
    - Health care costs that are not covered by insurance may contribute to higher uncompensated care costs paid for by other health care users, or higher public program costs if ultimately covered by public programs.
    - Concerns have been raised that a proliferation of lower cost insurance arrangements with limited coverage may "crowd out" other more comprehensive insurance

arrangements, resulting in fewer, more expensive insurance options for persons with high health care needs.

- While benefit designs with coverage limitations can be problematic, they may offer more-affordable insurance alternatives that meet important needs of many persons, especially those who cannot afford more traditional comprehensive coverage. They have the potential to provide better options for many than the current "all or nothing" choices which generally prevail, under which many are receiving nothing.
    - More limited coverage, while not as comprehensive as most insurance products currently marketed, can still provide not only individual financial protection and access to medical services, but may also help reduce uncompensated care and public program costs associated with uninsured persons.

- Determining health benefit levels may involve competing objectives and philosophies. For example, one approach to defining benefits is to identify the range of needed services to meet health needs, and then to determine the costs and prices of coverage to provide the services. This represents the traditional approach to health insurance. An alternative approach is to determine levels of insurance costs or prices that are considered feasible for broad groups of users, and then to determine what could be purchased or provided at a given price.

- Some promising alternatives and possible approaches to improving health care quality and reducing health benefit costs may be difficult to implement directly at this time on a large scale to result in near term savings.

  For example, in its 2005 report to the Legislature, the Health Care Guidelines Work Group noted:

  "While Minnesota and the United States have committed health care professionals who deliver excellent care under most circumstances, there is widespread evidence that there is substantial room for improvement in the delivery of health care services. ...Physicians and researchers have been working over the course of the past several decades to objectively and scientifically examine which care delivery models and methods work best for certain types of conditions and for the average patient under normal circumstances. The more widespread use of "evidence-based medicine" and the acceleration in the use of "best clinical practice" can improve patient care, provide better patient outcomes, and has the potential of lowering health care costs."[3]

  In its report, the Work Group also recommended a number of steps to facilitate the development and use of evidence-based medicine and best clinical practices. Many of the recommended steps are being undertaken. Conceptually, a further step that could be considered is a version of a "secure benefit set" that covered only scientifically proven medical practice. Such a strategy would provide coverage for important forms of medical care and treatment, and promote continued development and application of evidence-based medicine. However, at present there is good scientific evidence for only relatively limited amounts of medical practice. While it is important to acknowledge and foster higher quality health care and evidence-based practice, developing a secure benefit set that covers only currently scientifically proven practice would also be limited, leaving potentially large gaps and questions about coverage.

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[3] "Recommendations on Systems Improvements to Advance Evidence-Based Health Care," Report to the Legislature, Minnesota Department of Health, 2005

- However, even while some desired innovations or changes in benefit design are difficult to achieve at this time, there may be other alternatives and related strategies that could be considered. For example, an additional option to support development and use of scientifically-based health care guidelines is to explore ways to increasingly identify and reward "best in class providers" or limited "high value networks" of health care providers that deliver high quality care according to scientifically based guidelines.

  Provider rewards and incentives could take a variety of potential forms, including benefit designs with higher levels of benefit for accessing services through the designated networks or best in class providers. Another approach that could also be used in combination with those above, would be the use of "tiered" arrangements in which health care providers are placed into tiers based on their performance. Each tier is differentiated from the others through benefit differentials such as copays or deductibles that vary according to the tier of the provider that is selected for care. The current state employee health benefits program, Advantage, uses a tiered arrangement, which is briefly described in more detail later in this report.

- Finally, an important new issue in alternative health benefit designs or insurance products is information and assistance to employers, consumers, and others to help them make fully informed, wise choices. Because lower cost insurance arrangements may have limits or exclusions that are difficult to identify, understand or evaluate, it will be important to provide clear consumer disclosures of any coverage limits or exclusions. Clear scenarios should be provided to illustrate potential out-of-pocket costs and financial exposure.

V. Examples of approaches being used to introduce lower cost coverage alternatives

To date, a number of approaches and tools are being explored and or have recently been implemented as part of less expensive health insurance alternatives. Several common approaches, as well as some salient issues and trade-offs of the approaches, are briefly summarized below and help illustrate the issues described above.

Reductions, exemptions from state benefit mandates

This approach exempts some types of insurance from having to cover some or all benefits mandated in state statutes. In theory, elimination of mandates reduces the medical services and treatments that must be covered, resulting in lower premiums. However, in practice, researchers have found that mandated benefits are often in demand and would frequently be offered voluntarily, especially by larger employers, reducing the overall cost savings associated with mandate-free plans. For the most part, the mandate-free or limited mandate plans have not reduced costs to arrive at significantly lower price points and have not sold well in the market.[4]

[4] Minnesota currently has 26 "benefit mandates" that insurers must cover. According to a recent study, mandated benefits account for approximately 13% of total private health insurance premiums in Minnesota. However, most of the cost is due to mandated maternity coverage, which accounts for 6% of premiums. In many instances the mandates are generally accepted and researchers estimate that most would be offered voluntarily. The greatest difference is in the small group market, where approximately only 8.5% of the nearly 13% of costs of current mandates would be covered on a voluntary basis. While the potential reduction in premium costs due to mandated benefits are estimated to be greatest in the small group market, at 4.3% , the small group market is currently only 15% of the total Minnesota private health insurance market. As a result, elimination of mandated benefits was

Benefit caps, limits, exclusions

Insurance exclusions or limits can make premiums more affordable and still provide important levels of insurance protection. However, they come at a price for individuals who need the services that are limited or not covered. Consumers may also not be fully aware of the implications of insurance limits, or prepared to pay for uncovered expenses.

- Examples:
    - Annual caps on total benefit that will be paid (e.g., $50,000 or $100,000 maximum benefit)
    - Exclusions of types of services
        - e.g., No coverage for certain types of services, such as prescription drugs, inpatient services, chemical dependency, chiropractic, others
    - Limits – maximum daily, per visit, or annual limits
        - e.g., maximum limits on amounts that will be paid per day of inpatient hospitalization; coverage of only up to a certain amount for doctor's office visits or preventive care or prescription drugs.

Greater individual cost share

Increasing the individual's share of monthly premium costs, and/or the individual's cost at the point of service help keep employers' costs lower in order to offer health coverage and make contributions to employee coverage. However, this approach raises costs to consumers, including costs when services are provided that consumers may not have anticipated or budgeted.

Beyond the issue of who pays, there are also issues of the impact of greater consumer cost share on consumer behavior. Conventional, comprehensive health coverage with relatively low cost sharing for consumers is often believed to insulate them from the true costs of health care, leading to over-consumption of care, increasing demand for medical services, and contributing to health care cost escalation. Advocates of greater consumer cost sharing point out that if consumers were more directly aware of and engaged in paying health care costs, they will likely use fewer services and/or consider less expensive treatment alternatives when available. However, there are also concerns that it may be difficult for many consumers to shop effectively when they are ill or injured; that information needed for good decision making may be unavailable; and that consumers may be "penny wise" but "pound foolish" in not appropriately seeking care when needed, but then incurring even greater costs for more serious episodes of care later.

- Examples:
    - Increased monthly premium
    - Increased point of service costs such as deductibles, copays, and coinsurance
    - Variable pricing based on risk factors (e.g., charge smokers more, nonsmokers less)

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found to have relatively small impact in the overall Minnesota private insurance market, with an overall premium reduction averaging 1.3%.

In 1999, Minnesota created a three-year pilot program allowing insurers with less than 3% of total state market share to market insurance policies exempt from state benefit mandates except maternity coverage. Two insurers filed plans to offer the mandate-free policies, but later rescinded the plans when cost differences were not viewed as significant. More recently, legislation passed in 2005 allows any health plan to offer products that do not conform to state benefit mandates, with the exception of maternity coverage. As of the end of 2005, no insurers had yet submitted filings to offer such plans.

- While controversial, some employers are factoring certain health risks and behaviors, such as smoking, into pricing of premium rates and out of pocket expenses, charging smokers more but nonsmokers less.

Subsidies

A variety of direct and indirect subsidies have been made available to reduce health care costs for individuals, especially low income persons. While subsidies reduce costs for their recipients, the subsidies must be paid for through some means, raising costs to others. At the same time, subsidies may only further obscure the true costs of health care and health insurance.

Examples:

- Direct subsidies
  - There are many examples of direct means-tested subsidies to lower the costs of health insurance for individuals, including the state's MinnesotaCare program. (MinnesotaCare also includes benefit limits described above, especially on inpatient care, to reduce premium costs and to prevent "crowd out" of other forms of insurance that are already being paid for in the market.)
- Indirect subsidies
  - For example, the State of New York through the "Healthy New York" program, covers ninety percent of an individual's annual intermediate health costs greater than $5000 and less than $75,000. This form of state provided reinsurance represents an indirect subsidy intended to lower the cost of coverage for individuals and small employers. Minnesota has a similar reinsurance program for "purchasing alliances" (Minnesota Statutes § 256.956), but its impact has been very small due to low enrollment.

Discounts

Discounting arrangements are not insurance, but simply discounts off retail prices that consumers would otherwise pay for health care services. Initially often developed and promoted as tools to aid consumers without prescription drug coverage to obtain less expensive prescription drugs, discount arrangements are being widely marketed for many health care services.

While much less expensive than conventional insurance, discount cards do not provide the financial protection or access to health care services of conventional insurance. However, it should be observed that discounts are an important component of health insurance plans. Even services which might not be covered by a limited benefit plan due to caps or limitations would still receive the benefit of the health plan's discount, providing some relief to the consumer.

New approaches, models

Employers, providers, government, and others are actively exploring new benefit designs and value-based purchasing arrangements to reduce health care costs and improve the quality and value of health care expenditures. Some examples include:

- *Tiered benefit designs*, in which health care providers are placed into tiers based on their performance. The tiers can be differentiated for consumers on the basis of premium differentials and/or different costs at the point of service to encourage consumers to access less costly, higher quality providers.

  The State of Minnesota employee health benefit plan, known as Advantage, is one example of a tiered program in practice. Advantage serves the more than 115,000 employees and

family members of the State Employee Group Insurance Program (SEGIP). It places primary care clinics available to state employees into one of four cost levels, based on their risk-adjusted cost of delivering care and as negotiated in collective bargaining. Advantage members may then choose any primary care clinic that is available, but they pay higher copays, deductible, and coinsurance for more costly choices. In addition, during the recent annual open enrollment for employees, links were provided in open enrollment materials to the MN Community Measurement website, which provides information on how over 50 different clinic systems, representing more than 700 clinics, compared on quality.

Advantage gives consumers choices and information that they have never had before, while creating new market pressures and incentives for health care providers to deliver efficient, high value care. As a result, Advantage costs did not increase this year, and the program received a competitive "Innovation in State Government" award from the Council of State Governments.

- *Pay for Performance, Centers of Excellence.* A number of employers are exploring value-based purchasing concepts to reward high performing health care providers, including special pay for performance initiatives such as the "Bridges to Excellence" program, and others. Others are examining and adopting Centers of Excellence programs to identify "best in class" care delivery and to reward it through special payment rewards and/or increased patient volume.

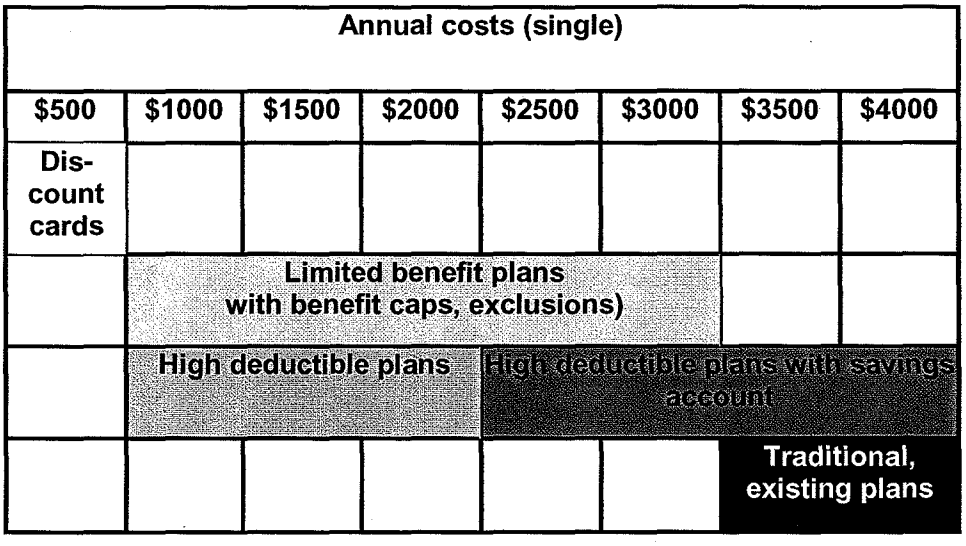
- *High deductible, "Consumer Driven Health Plans" coupled with savings accounts.* Under these arrangements, insurance products are offered with high deductibles but lower premiums, coupled with special savings accounts that can be used to pay for services for which the deductible applies, or for other services that may not be part of conventional health insurance offerings. In some cases, remaining balances in the savings accounts can be rolled over from one year to the next, creating incentives to access and use care carefully so as not to use up the value of the health care savings account.

Many of these new approaches are being rapidly deployed and adopted in the health care market. For example, the recent Medicare Modernization Act, which established prescription drug coverage for Medicare, also created Health Care Savings Accounts (HSAs) used in conjunction with high deductible consumer driven health plans. Such consumer driven health plans are among the most rapidly growing types of new health coverage products. Tiered arrangements are in place for not only state employees, but have been recently announced by the state's major health plans for Minnesotans generally. Pay for performance models and initiatives are being adopted both nationally and locally.

VI. Examples of relative pricing of various benefit design alternatives

To provide further perspective on health care benefit options and tradeoffs, an illustrative "benefits space" with relative price ranges of different benefit alternatives is provided below. For example, health care discount cards are often available in a range of prices, depending on the size of the discounts and the array of applicable products and services. Typically, discount cards are often priced in the range of $50 per month ($600 per year) or even much less, for single persons. At the other end of the spectrum are traditional employer based health plans, averaging over $300 per month for single coverage, or over $3600 per year.

Relative Pricing of Various Benefit Design Alternatives



DOER's consulting actuaries at Deloitte Consulting LLP further explored the range of costs and tradeoffs above by comparing several types of benefit designs recently introduced into the market. For the purpose of this comparison, prices of several types of recently available health insurance products were calculated using the experience of the state employee group as an initial proxy for possible PEIP experience. The pricing estimates were preliminary, and intended only for illustrative purposes. The pricing estimates were then compared across ranges of monthly premium levels for single (employee only) coverage, to illustrate what different premium amounts might buy. The relative levels of coverage and costs of the comparison are summarized below.

Monthly single premium range	Some Typical Features and Plan Design
$50 - $100	• Little or no inpatient coverage • No prescription drug coverage • Little or no office visit coverage • Annual caps and limits (e.g., maximum annual benefit payout of $100,000)
$100 - $150	• Limited inpatient coverage (capped payments per day, or subject to high coinsurance) • No prescription drug coverage • Deductibles and coinsurance • Some annual caps and limits (e.g., maximum annual benefit payout of $50,000)
$150 - $200	• Inpatient covered, subject to coinsurance • No prescription drug coverage • Deductibles, coinsurance • Some annual caps and limits (e.g., maximum annual benefit payout of $50,000 - $100,000)
$200 - $250	• Inpatient covered, subject to coinsurance • Some limited prescription drug coverage (at mid to high end of range) • Deductibles, coinsurance • Some annual caps and limits (e.g., maximum annual benefit payout of $50,000 - $100,000)
$250 - $300	• More like traditional health benefit plans • Coinsurance and deductibles • No annual caps or limits • Copays for prescription drugs in some cases

As shown above, the lower the monthly premium cost, the fewer the covered services and the greater the consumer cost share at the time services are delivered. In particular, at monthly premium prices below $150-$200 per month, it is difficult to cover significant categories of services such as inpatient care and prescription drugs. Both these categories are often key to caring for persons with complex or chronic conditions, and important components of both preventive and catastrophic coverage called for in the HCPA study legislation regarding secure benefits.

Preliminary Conclusion/Observation

In attempting to develop a secure benefit set, the more affordable the plan, the less secure the coverage for the individual. Defining "catastrophic coverage" in an acceptable manner is a key element in developing an affordable plan. If the definition could be limited to $50,000 per individual, the affordability index is significantly increased. In a typical population, this would meet the needs of a high percentage of participants. However, a small percentage would exceed the maximum limit placing a significant financial burden on the participant or ultimately, the health care providers. Setting the limit higher moves the projected cost of coverage into the cost range of traditional plans. A second key element is defining "preventive coverage." Left to the definition assigned by most traditional health plans, it would cover a relatively small number of services. Many would argue that in the context of a limited benefit plan scenario that it should

be expanded to include treatment for conditions, which left undertreated will lead to catastrophic cases (e.g., diabetes, asthma, heart conditions). Finally, balancing some minimal level of initial care to enable early diagnosis of conditions against limiting benefits to hold down cost becomes the third element to consider. These issues will need to be further explored, discussed, and debated as the secure benefit set is developed.

VII. Next Steps and Opportunities

Current levels of comprehensive health benefits and coverage have helped provide those with such coverage access to a wide range of medical services and financial security but at high and growing costs. In the absence of other alternatives, many employers and individuals are faced with "all or nothing" health insurance coverage alternatives. Many are no longer able to afford current levels of coverage and costs.

DOER will continue to build on this preliminary planning to explore options for lower cost insurance products to be available through PEIP. In particular, DOER plans to:

- Capitalize on the success of its tiered arrangement for state employees, known as Advantage, by exploring similar arrangements that could be available through PEIP.

- More fully develop and analyze the business case for a secure benefit set available through PEIP, especially in relation to:
    - Insurance choices and arrangements otherwise available to PEIP-eligible groups;
    - Intrinsic choices and trade-offs among benefit design alternatives;
    - Impacts on PEIP, including potential changes in the number and type of groups who may become part of PEIP, as well as related staffing, reserving, and other PEIP administrative and management issues;
    - Overall costs and benefits of any changes.

- Meet with and discuss benefits design issues with PEIP-eligible public employers and stakeholders;

- Continue to monitor the health care market and to identify other innovative health benefit designs and options.