

Statement



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Pharmaceutical Research and Manufacturers of America**

before the

**Committee on Finance
United States Senate**

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INTRODUCTION

Mr. Chairman, Senator Moynihan, and other members of the Committee. I'm pleased to be here on behalf of America's innovative pharmaceutical industry to discuss an issue that is vitally important to all of us--prescription drug coverage for seniors and disabled citizens. Across America, 50,000 scientists in our research labs work day and night in hopes of finding the next cure or the next treatment, to allow individuals to live long, healthy, and productive lives (see Attachment 1). On average, it takes 12 to 15 years and \$500 million to develop a new drug and bring it to market.

Today, industry has more than 1,000 new medicines in development to treat hundreds of serious illnesses including Alzheimer's and Parkinson's diseases, cancer, stroke, arthritis, and depression. We are confident that, in time, we will find the cures for these and other conditions that are so prevalent among our aging population (see Attachment 2).

The 21st Century brings even greater promise. As the human genome is mapped, many new targets for pharmaceutical innovation will be identified. Currently about 500 targets for drug interventions are known. This figure is expected to increase to 3,000 to 10,000 drug targets in the near future. When these new cures and treatments are brought to market, we want to ensure that seniors have access to them--without discouraging the discovery and development of new medicines.

In our discussions, I hope that we all can begin by agreeing on at least four key points:

First, expanded drug coverage for seniors will happen. At some point in the not-too-distant future, a Congress will pass, and a President will sign, legislation to expand drug coverage for Medicare beneficiaries. It's going to happen, and the pharmaceutical

industry wants to be part of the solution. Most Medicare beneficiaries have prescription drug coverage either through their (or their spouse's) current or former employer, a Medicare supplemental insurance (or Medigap) policy, a Medicare+Choice plan, or by qualifying for Medicaid or other governmental programs. But many of those who do not receive the coverage they need through these mechanisms require additional assistance.

Second, expanded drug coverage for seniors will be a positive development. Prescription drugs are increasingly the most effective and cost-effective therapy with which to treat diseases or conditions. Some Medicare beneficiaries are in need of prescription drug coverage and our medicines provide extraordinary value to them.

Third, as we expand drug coverage for seniors, we must sustain the American pharmaceutical industry's worldwide leadership. The industry has developed new medicines that benefit all patients--young and old--and we do not want to harm the environment in the U.S. that has allowed our industry to thrive. In the 1990s alone, 370 prescription drugs, biologics, and vaccines developed by industry were approved for patients' use with a physician's prescription. Almost half of all new medicines in the world are discovered by the U.S. industry (see Attachment 3). We are the world's leader in pharmaceutical research and development (see Attachment 4).

As we work together to expand access to prescription drug coverage, we must remember that Medicare beneficiaries want access to new medicines because they were invented.

Finally, we need to always remember to put the interests of patients first. In an environment where we discuss 10-year forecasts, adverse selection, risk pools, and premium calculations, it is sometimes difficult to remember that the real focus must always be on patients. In moving forward, we must always focus on what type of expanded Medicare drug coverage will be best for patients, their children, and their grandchildren--who need access to medicines, but who also need the discovery of medicines that today exist only in our dreams.

SUPPORT COMPREHENSIVE MEDICARE REFORM

The pharmaceutical industry strongly supports strengthening and modernizing Medicare, including expanding Medicare coverage of prescription medicines (see Attachment 5). We believe that today's Medicare structure does not effectively meet the health care needs of today's seniors and disabled citizens. Medicare beneficiaries need high-quality health care, and prescription medicines often offer the most effective therapy for them.

We believe that the best way to expand prescription drug coverage for Medicare beneficiaries is through comprehensive Medicare reform. The current program is based on a 1960s-style, one-size-fits-all model that relies on centralized price controls and

complex regulations. The result is a program that is confusing for patients and providers, difficult to administer, and inadequate to meet the health care needs of the 21st century.

In his Fiscal Year 2001 budget, the President proposed several initiatives to “reform” the Medicare program. However, these policy modifications do not modernize Medicare because they would not change the fundamental structure of the Medicare program nor increase the long-term financial stability of the program. Rather, they would simply institute new centralized payment policies and regulatory authorities.

Likewise, the Administration offered a new prescription drug benefit that it claimed would rely on private market forces to foster competition. But this plan would offer a one-size-fits-all benefit design and would simply use private entities to administer the program, as they do currently for hospitals, physicians, and other services.

The Administration claims that its proposal contains no price controls and ensures patients’ access to medicines. But we believe that price controls and limits on access to medicine would be the inevitable outcome of any HCFA-administered plan.

We believe that seniors deserve more choices than the “yes” or “no” that characterizes the Administration’s plan. We agree with Sen. Breaux who said that the “competition” the Administration’s plan would provide is a “distant second cousin” to real competition. Allowing private entities to 1) bear the risk, 2) offer a variety of plans, and 3) compete for customers based on quality and cost, would ensure real competition.

Indeed, a reformed Medicare program would use the power of the marketplace to foster competition among private plans, resulting in more choices of high quality for Medicare beneficiaries. Seniors and disabled Americans could then select a plan that meets their individual needs. With this market-based approach, the Medicare program would evolve to reflect changes in the medical marketplace. The right reforms would expand prescription drug access for all, provide special assistance to those in need, and deliver high-quality care.

We do not need to look far for a model that incorporates many good design elements—the Federal Employees Health Benefits Program (FEHBP). Each year, Members of Congress, 9 million Federal employees (and retirees), and their families choose a comprehensive health insurance plan from the wide range offered by different kinds of competing private entities. These plans provide both quality care and good value. Most Federal employees enroll in preferred provider organizations (PPOs); others enroll in health maintenance organizations (HMOs). Almost all Federal employees are very satisfied with their health care.

Some Medicare beneficiaries already receive their coverage from a private entity, rather than remaining in traditional fee-for-service Medicare. Beneficiaries who choose a Medicare+Choice plan often find that they have lower out-of-pocket costs, better coordination of care, and receive extra benefits—including prescription drug coverage.

Nationwide, 16 percent of Medicare beneficiaries choose this option. However, participation in Medicare+Choice varies by geographic area--often reflecting trends in the under-65 market. For example, in parts of northern California, nearly half of the beneficiaries receive their Medicare benefit from a private plan. In other parts of the country, especially rural areas, beneficiaries have only one option--traditional Medicare. Today, nearly two-thirds of beneficiaries have access to a Medicare+Choice plan that includes some form of prescription drug coverage. A modernized Medicare program would foster competition among plans and provide even more private plan options for all beneficiaries that include prescription drugs.

Senators Breaux, Frist, Kerrey, and Hagel recognize the importance of fundamental reform of the Medicare program and introduced the Medicare Preservation and Improvement Act (S. 1895). This bill represents a commitment to making Medicare financially sound and more responsive to the needs of seniors by using a market-based approach. Under this plan, all health plans would compete to enroll Medicare beneficiaries. Consumer choice would drive plans to provide better--and more cost-effective--health care.

America's innovative pharmaceutical manufacturers recognize that modernizing Medicare to increase prescription drug coverage, while preserving and protecting these vulnerable populations, is as complex as it is important. We are committed to comprehensive Medicare reform with private sector delivery, and pledge to work with Congress to achieve this goal.

INCREMENTAL MEASURES TO INCREASE ACCESS

If the Congress decides to pursue interim measures pending longer term comprehensive reform, PhRMA would support efforts to increase access to prescription drug coverage, so long as they would improve, rather than impede, opportunities for future comprehensive reform.

We are encouraged by the Seniors Prescription Insurance Coverage Equity Act (SPICE) (S. 1480) introduced by Sens. Snowe and Wyden. This bill would provide beneficiaries with access to prescription drugs by subsidizing the purchase of a supplemental policy, enrollment in a Medicare+Choice plan, or through an employer-provided group health plan. It provides opportunities for private market competition and more choices.

With respect to the delivery system for any proposal, policy makers need to ask:

- Should the drug benefit be delivered by the government or the private sector?
- Should the benefit be a single, one-size-fits-all program, or should seniors and disabled beneficiaries have a range of choices?

We believe several principles are key components of any interim proposal. As Congress continues to grapple with this complex issue, we will support proposals consistent with these key principles:

- All beneficiaries would have the ability to enroll in a private insurance coverage plan of their choosing, ranging from private fee-for-service to HMOs and various private-sector options in between.
- Federal subsidies would help low-income beneficiaries afford coverage.
- Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.
- Beneficiaries would have access to all medicines.
- Plans should be overseen by a new, independent government entity.
- The new program would be consistent with, and a step toward, needed comprehensive modernization of the Medicare program.
- Coverage would be offered through competing, private insurance or health plans that rely on marketplace competition to control costs and improve quality.

Government price controls are unacceptable to the industry, because they would inevitably harm our ability to bring new medicines to patients. We urge you to say “no” to price controls in any form, not direct price controls, not indirect price controls, not by design, not by accident, not by stealth, not by baby steps.

A PRIVATE INSURANCE INCREMENTAL APPROACH

The pharmaceutical industry believes that if Congress decides to provide an incremental prescription drug benefit, the best approach would be to provide seniors access to private insurance products. This approach would fit easily into the current marketplace, since well over 150 million people get their drug coverage through private entities. In delivering drug coverage, these private entities would do more than simply pay the claims. **They could provide disease management programs, drug utilization review, patient education, and help to reduce medical errors.** We in the research-based pharmaceutical industry believe that seniors and disabled beneficiaries would benefit greatly by having access to these private insurance products, with the government providing subsidies for those in need.

Skeptics point to complex issues, such as “adverse selection,” and claim that a private insurance program will not work. Adverse selection can occur because individuals purchase insurance only when it is in their best interest. If an individual could purchase insurance at any time, it would be perfectly rational for them to wait until they were sick.

Consequently, insurers often place limits on when individuals can purchase insurance and under what conditions.

Recognizing that adverse selection is an important issue, we asked the experts for assistance. We turned to leading actuarial and economic firms including Milliman and Robertson, Abt Associates, and Towers-Perrin and commissioned analyses (see Attachments 6, 7, and 8). These actuaries and economists note that a private prescription drug insurance program can work if designed properly. They also note that adverse selection is “one of the most difficult issues in designing any insurance program involving individual choice.” Actuaries and economists have several tools to minimize the impact on adverse selection. These include:

- Limiting election opportunities for enrollment;
- Providing low-income subsidies for premiums and deductibles;
- Establishing a high-risk pool for enrollees with very high expenditures;
- Requiring up-front cost sharing, such as an annual deductible; and
- Allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

We believe that a properly designed prescription drug insurance benefit would attract many Medicare purchasers and many private market sellers. Why are we so confident? In the market today, there are private health insurance policies for cancer, sports accidents, emergency room visits, pregnancy complications, and campers. There are private insurance products for goats, carriage rides, and the weather on the day of your daughter’s wedding (see Attachment 9). We believe that there are similar opportunities for private-market solutions to increase access to prescription drug coverage for the elderly and disabled Americans.

CONCLUSION

In my testimony today, I’ve tried to highlight the pharmaceutical industry’s support for expanded drug coverage for seniors--done the correct way.

Some say that this issue is life or death for the pharmaceutical industry, America’s premier high-technology industry. After the debate is over, and the dust settles, we will still have a pharmaceutical industry, but depending on what you do, the industry could be profoundly different, and the results for patients could be demonstrably less.

As the debate unfolds, I hope you’ll remember the millions of Americans, like my children, waiting impatiently for new cures and treatments. We can provide quality health care for seniors and the disabled, including better prescription drug coverage, but we need to do it the correct way. If we do it the wrong way, the industry and the patients we serve will undoubtedly suffer the consequences.

ATTACHMENT 1

THE RESEARCH-BASED PHARMACEUTICAL INDUSTRY: FACTS AT A GLANCE

A Strong Commitment to Research and Development

- This year, research-based pharmaceutical companies will invest \$26.4 billion in research and development (R&D) on innovative new medicines. This represents an increase of 10.1 percent over research spending in 1999. Since 1980, research-based companies have multiplied their R&D investment 13-fold.
- Domestic R&D is expected to increase by nearly 12 percent in 2000.
- R&D conducted abroad by U.S. based companies will grow only 1.2 percent - a clear sign that the American system nurtures innovation and discovery.
- Over the past two decades, the percentage of sales allocated to pharmaceutical R&D has increased from 11.9 percent in 1980 to approximately 20.3 percent in 2000, higher than virtually any other industry. The average for all U.S. industries is less than four percent.
- Approximately 36 percent of pharmaceutical R&D conducted by companies worldwide is performed in the United States, followed by Japan with 19 percent.
- This U.S. industry investment is very efficient. Of 152 major global drugs developed between 1975 and 1994, 45 percent are of U.S. origin.

Drug Discovery and Development Are High-Risk

- During the 1990s, the average time it took to discover, test and develop a single new drug increased to nearly 15 years. This was almost twice the development time in the 1960s.
- Of every 5,000-10,000 compounds tested, only five enter human clinical trials, and only one is approved by the FDA for sale in the U.S. Of every 10 medicines in the market, on average, only three generate revenues that meet or exceed average R&D costs.
- The Boston Consulting Group estimates that the pre-tax cost of developing a drug introduced in 1990 was \$500 million, including the cost of research failures and interest over the period of investment.

Medicines in Development

- The research-based pharmaceutical industry currently has more than 1,000 new medicines in development to treat hundreds of serious diseases.
 - There are currently 369 biotech medicines in the pipeline to combat over 200 diseases. Nearly half the medicines - 175 - are for cancer, the second leading killer of Americans. Biotechnology and new technological tools have revolutionized cancer research.
 - Among these drugs and biologics in development are promising new treatments for cancer, heart disease, Alzheimer's, AIDS, diabetes, multiple sclerosis, Parkinson's, stroke, rheumatoid arthritis, and depression.

The Value of Medicines

- The estimated life expectancy of an American born in 1920 was 54 years. By 1965, life expectancy had increased to 70 years. The average American born today can expect to live more than 76 years, and life expectancy has risen dramatically for all age groups. Every five years since 1965, roughly one additional year has been added to life expectancy at birth. These improvements in life expectancy are due advances in medicine and our improved ability to prevent and treat disease:
 - Antibiotics and vaccines have virtually wiped out such diseases as diphtheria, syphilis, whooping cough, measles and polio in the U.S.
 - The influenza epidemic of 1918 killed more people than all the battles fought during the First World War. Since that time, medicines have helped reduce the combined U.S. death rate from influenza and pneumonia by 85 percent.
 - Over the past 30 years, innovative medicines have helped reduce deaths from heart disease and stroke by half, enabling 4 million Americans to live longer, better lives.
 - Since 1965, drugs have helped cut emphysema deaths by 57 percent and ulcer deaths by 72 percent.
- In a year-long disease-management program for about 1,100 patients with congestive heart failure run by Humana Hospitals, pharmacy costs increased by 60 percent, while hospital costs (the largest component of U.S. health care spending) declined 78 percent. The net savings were \$9.3 million.
- A National Institutes of Health (NIH) study showed that while it initially costs more to treat stroke patients with a clot-busting drug, the expense is more than offset by

reduced hospital rehabilitation and nursing home costs. Treatment with the clot-buster costs an additional \$1,700 per patient, but reduced hospital rehabilitation and nursing home costs result in net savings of more than \$4,000 per patient.

- According to a study published in the *New England Journal of Medicine*, the use of ACE inhibitor drugs for patients with congestive heart failure reduced mortality by 16 percent, avoiding \$9,000 in hospital costs per patient over a three-year period. Considering the numbers of people at risk for congestive heart failure, additional use of ACE inhibitors could potentially save \$2 billion annually.
- According to a study conducted at the University of Maryland Medical Center, patients treated with beta-blockers following a heart attack were up to 40 percent less likely to die in the two-year period following the heart attack than the patients that did not receive the drugs. According to another study, use of beta-blockers resulted in an annual cost savings of up to \$3 billion in preventing second heart attacks and up to \$237 million in treating angina.
 - Unfortunately, a study published in the *Journal of the American Medical Association* found that only half the people who could be helped by these medicines are getting them.
- Estrogen-replacement therapy can help aging women avoid osteoporosis and crippling hip fractures, a major cause of nursing home admissions. Estrogen-replacement therapy costs approximately \$3,000 for 15 years of treatment, while a hip fracture costs an estimated \$41,000.
- The combination of two drugs, at a cost of about \$140 can eradicate the bacterial cause of most ulcers. Ulcer surgery costs upward of \$28,000.

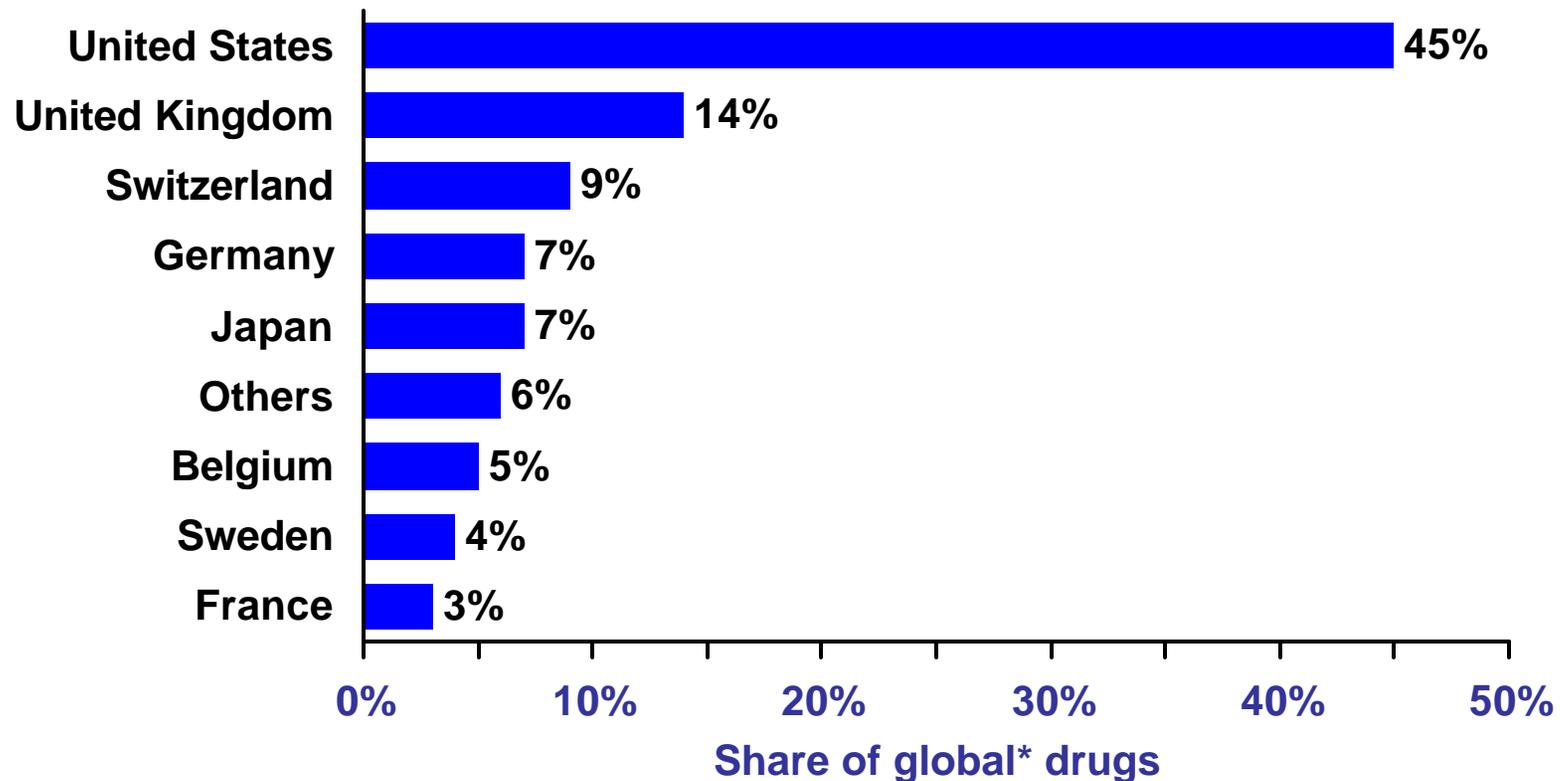
Prevalence, Cost, and Medicines in Development for Selected Major Diseases in the United States

<u>Uncured Disease</u>	<u>Approximate Prevalence</u>	<u>Approximate Annual Economic Cost (\$billions)</u>	<u>Number of Medicines in Development*</u>	<u>Source</u>
Alzheimer's Disease	4,000,000	\$100.0	23	National Institute on Aging
Arthritis	40,000,000	\$54.6	28	Arthritis Foundation
Asthma	14,000,000	\$6.2	17	National Heart Lung and Blood Institute
Cancer	8,000,000	\$107.0	316	American Cancer Society
Congestive Heart Failure	4,900,000	\$20.2	17	American Heart Association
Coronary Heart Disease	13,900,000	\$95.6	38	American Heart Association
Depression	17,600,000	\$53.0	17	National Institute on Mental Health
Diabetes	15,700,000	\$98.2	19	National Institute of Diabetes
Hypertensive Disease	50,000,000	\$31.7	10	American Heart Association
Osteoporosis	10,000,000	\$13.8	24	National Osteoporosis Foundation
Schizophrenia	1,500,000	\$23.0	12	National Institute of Mental Health
Stroke	4,000,000	\$43.3	22	American Heart Association

*PhRMA data.

Source: Compiled by PhRMA, 2000.

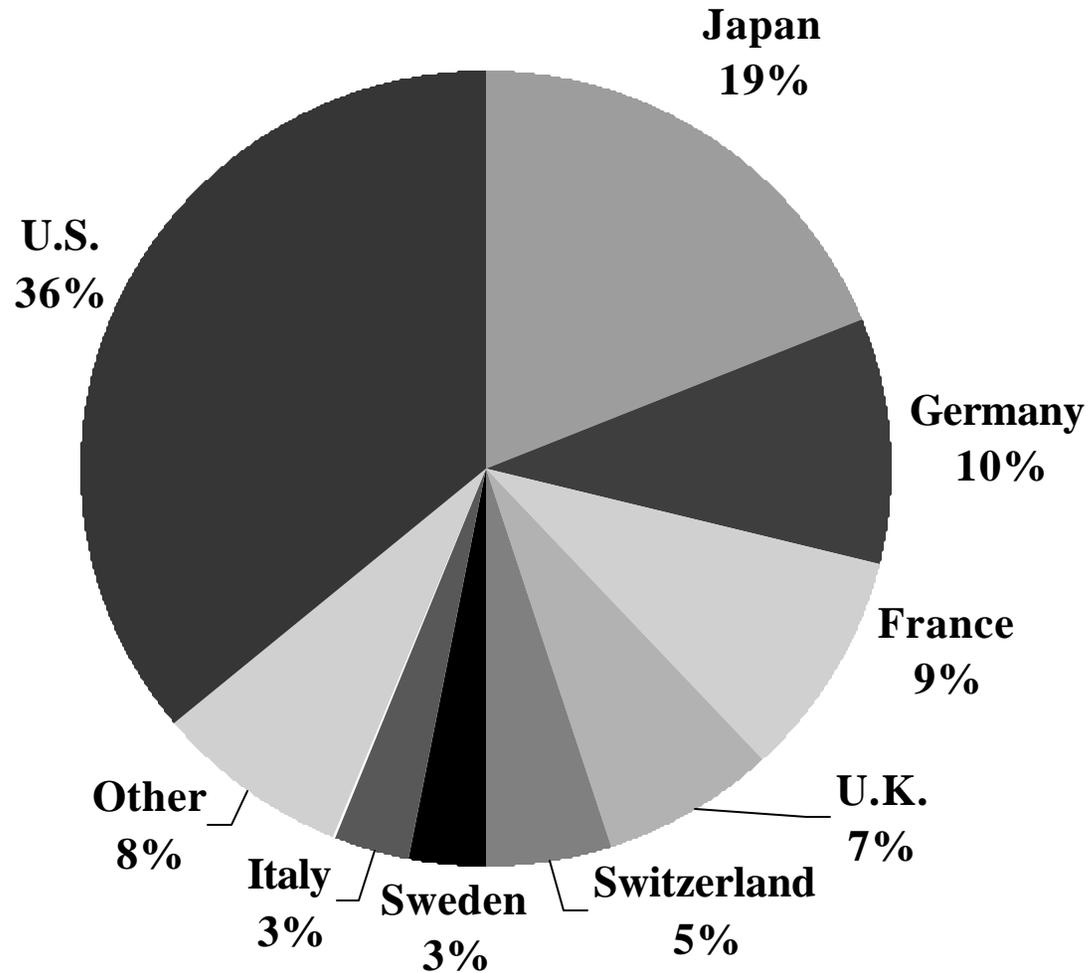
Development of 152 Global* Drugs by Country of Origin, 1975–1994



**Global drugs: Launched in U.S., Japan, France, Germany, U.K., Italy and Switzerland.*

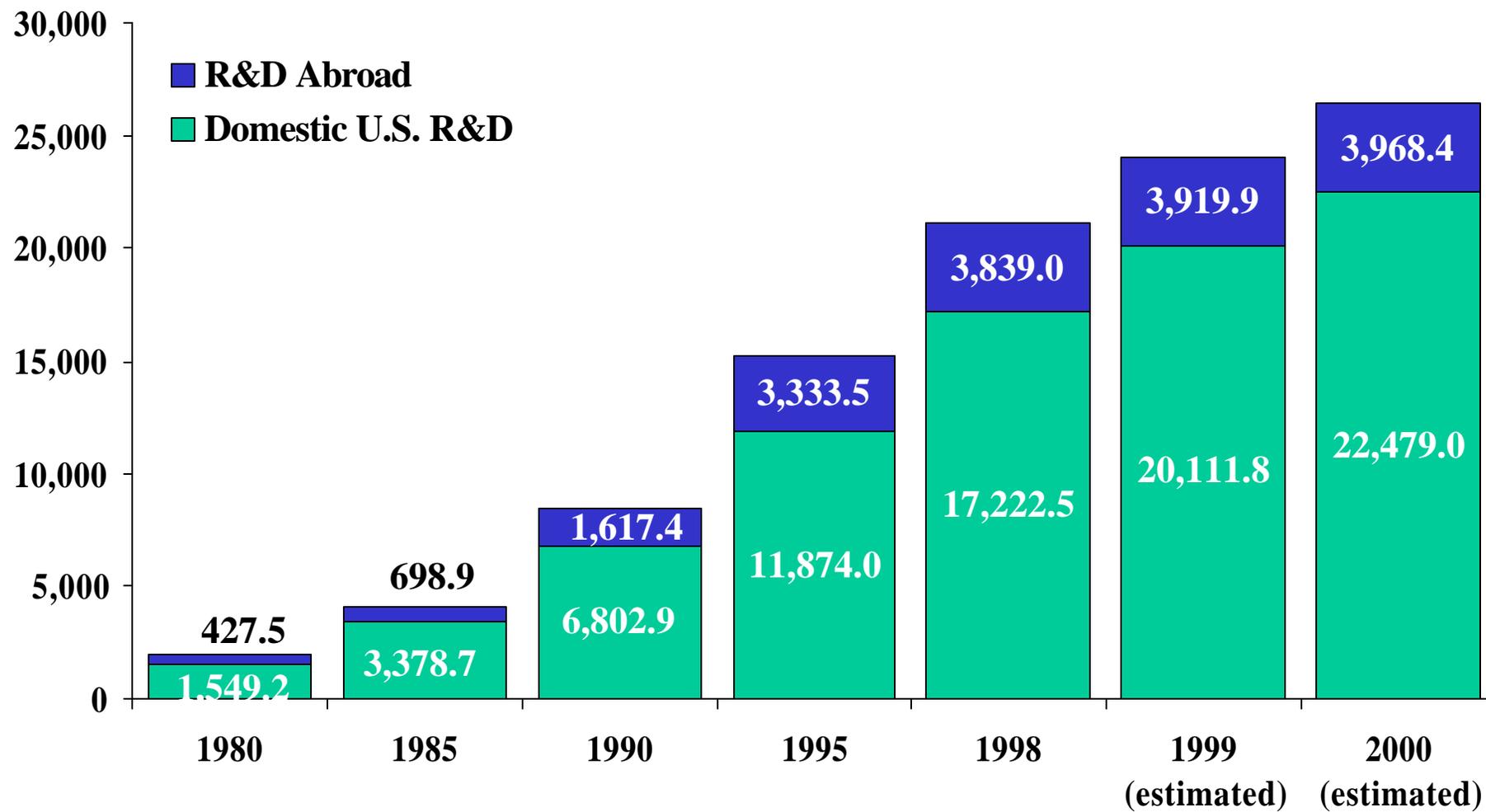
Source: Barral, P.E., 20 Years of Pharmaceutical Research Results Throughout the World, Rhone-Poulenc Rorer Foundation, 1996.

Company-Financed Pharmaceutical Research & Development by Location, 1997



Source: Centre for Medicines Research, U.K., 1999.

R&D Expenditures, Research-Based Pharmaceutical Companies 1980-2000



Source: PhRMA Annual Survey, 2000.

PhRMA Medicare Prescription Drug Position

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports pharmaceutical coverage for Medicare beneficiaries. We believe that the best way to provide pharmaceutical coverage to Medicare beneficiaries is through comprehensive modernization of the Medicare program to provide beneficiaries a choice of health plans that would also provide drug coverage. If such modernization does not occur this year, PhRMA would support federal legislation that would provide all seniors with access to pharmaceutical insurance coverage, wherever they live and no matter how sick they are.

Such a proposal would have the following elements:

- 1. All beneficiaries would have the ability to enroll in a pharmaceutical coverage plan of their choosing.**
- 2. Federal government subsidies would help low-income beneficiaries afford coverage.**
- 3. Coverage would be offered through competing, private insurance plans that rely on marketplace competition to control costs and improve quality.**
- 4. Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.**
- 5. Beneficiaries would have access to all medicines.**
- 6. Plans would be overseen by a new, independent government entity.**
- 7. This new program would be consistent with, and step toward, needed comprehensive modernization of the Medicare program.**

Several existing proposals embody these elements in whole or part. We offer our assistance and support in advancing the goal of enhanced pharmaceutical coverage this year.

January 17, 2000



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**Design Elements in a Private Medicare Insurance Program
for Prescription Drugs
*Issue Brief***

A private prescription drug insurance program for Medicare enrollees could be viable if certain design elements are in place. The purpose of this issue brief is to identify those critical design elements and parameters. This brief is designed for an audience familiar with: 1) the Medicare program, 2) currently available prescription drug insurance options (e.g. Medicare supplemental policies and the Medicare+Choice program), as well as 3) a basic understanding of risk and the operation of the insurance industry.

The Pharmaceutical Research and Manufacturers of America has retained Stephen M. Cigich, F.S.A., M.A.A.A. of Milliman & Robertson, Inc. to prepare this issue brief. This brief is based on actuarial modeling and analysis regarding the impact of adverse selection, and reflects the author's actuarial judgment and opinion.

BACKGROUND

Private insurers would consider many issues in determining whether to participate in a prescription drug insurance program for Medicare enrollees. Issues include parameters placed on program design elements such as: the general program design (premium structure and cost sharing), pharmacy network structure, prescription drug interventions and formulary usage, pricing for future estimated utilization and cost trends, enrollment rules, existing prescription drug programs, regulatory oversight, and government subsidy mechanisms. Additionally, insurers would need to consider the possibility of future legislative changes that may have adverse effects.

Private insurers would also need to address one of the most difficult issues in designing any insurance program involving individual choice — adverse selection. This is especially true for a stand-alone prescription drug program for Medicare enrollees. However, a carefully designed program that includes the features outlined in this paper could substantially control the effects of adverse selection.

ADVERSE SELECTION - DEFINED

Adverse selection arises when potential enrollees purchase private insurance only when they believe it is in their financial interest to do so. Most people can estimate their near-term future prescription drug spending with reasonable accuracy. Barring an unforeseen change in health, a person can determine if they benefit from enrolling in a private plan based on a review of their recent prescription drug spending. This determination becomes less clear if a person must consider the need for coverage over their remaining lifetime.

Adverse selection can be measured as the increase in the per capita cost of the population electing the private plan to the per capita cost of all of those who were eligible to elect the private plan. For example, we project the average per capita drug spending, ignoring managed care discounts, in calendar year 2000 to be \$1,243 per person for all current aged enrollees. However, the distribution in average annual drug costs by quartile is striking: \$55, \$459, \$1,182, and \$3,277. If all current aged enrollees join the plan (i.e., election rate equals 100%), the average drug spending would also be \$1,243 and adverse selection would be 0%. At the other extreme, if only the 25% with the highest annual drug spending (\$3,277) enrolled, then adverse selection would be 164% [$=(\$3,277-\$1,243)/\$1,243$].

Under a private insurance program, the initial first-year offering to all current enrollees creates the biggest potential for adverse selection impact. The fact that there are approximately 37 million people in this category magnifies the potential impact of misestimating adverse selection.

DESIGN ELEMENTS TO CONTROL ADVERSE SELECTION

Adverse selection is dynamic. The higher the average private insurance plan cost, the greater the impact of adverse selection as people with lower prescription expenses elect not to join. Consequently, program features designed to keep costs low will help in controlling adverse selection. These elements include:

Limited One-time Election Opportunity - A limited one-time election opportunity would encourage Medicare recipients to consider factors beyond the near-term in making their election decision, resulting in higher enrollment levels and reduced adverse selection.

Catastrophic Benefit Design Emphasis - A benefit design that emphasizes catastrophic protection (providing full coverage when the enrollees' calendar year prescription expenses exceed a threshold level) introduces an important protection against adverse selection. A catastrophic benefit not only protects enrollees against an uncertain future financial event; it changes their frame of reference from enrolling in a plan to obtain coverage for incidental expenses to enrolling in the plan to obtain coverage for expenses that they potentially may not be able to afford. A catastrophic benefit would necessitate up-front cost sharing features, such as annual deductibles, to help keep the premiums low.

Management Techniques - Allowing insurers to establish contractual relationships with pharmaceutical manufacturers and distribution networks would lessen product costs and thus premiums. Formularies and utilization management programs would also control expenditures.

Low-Income Subsidy - Subsidies for both premiums and deductibles for low-income enrollees would encourage their enrollment. Thus, low-income subsidies are an effective way to enroll a significant number of potential enrollees with a broad range of prescription drug costs into the program, thus reducing the level of adverse selection.

High-Risk Pool and Subsidy - A subsidized high-risk pool would allow insurers to segregate the highest users of prescription drugs from their community rate pool. By eliminating the excess cost of these individuals, the community rate level supporting all other enrollees falls. Additionally, the level of claims variance in the insurers' community rate pool falls as well. Lower claims variance provides a greater level of stability and predictability to insurance company pricing.

AN ILLUSTRATION OF A PRIVATE INSURANCE OPTION

The following is an illustration of a private insurance option for prescription drugs that incorporates these elements:

- ◆ All current Medicare enrollees (Initial Eligibles) and future Medicare enrollees (Future Eligibles) would be offered a one-time, limited opportunity to buy prescription drug insurance from private insurers on a guaranteed issue, community rated basis.
- ◆ A one-time, 6-month enrollment window would be established whereby Eligibles would be allowed to enroll on a guaranteed issue, community-rated basis. Eligibles who did not enroll during the enrollment window would apply for coverage later, but would be subject to insurance company underwriting requirements.
- ◆ Premium subsidies would be offered to individuals with incomes below a certain percentage of the poverty level. Eligibles at or below a defined income threshold would have their entire premium and any benefit deductibles paid by the government. Subsidies would be graduated so that Eligibles above a certain income level would receive no subsidy.
- ◆ High risk pools would be established to mitigate the impact the highest users of prescription drugs would have on the insurers' community rates. The government would publicly fund benefit expenditures for these high-risk individuals in excess of the community rate.
- ◆ Benefit management methods such as participating pharmacy networks, formularies, and utilization management would be permitted.
- ◆ The benefit would be designed to emphasize catastrophic protection while keeping the community premium rate reasonably low.

Addressing Issues for Private Sector Provision of Drug Insurance

Marian V. Wrobel, Ph.D., and David Kidder, Ph.D.
Abt Associates, Inc.
March, 2000

Introduction

Prescription drugs play an essential role in the treatment of disease, but providing these therapies may be costly and may impose financial burdens on the people who require them. Drug costs represent a growing share of total medical costs largely due to the growing importance of prescription medications in the treatment of disease and the increased use of these drugs.

Many individuals, including Medicare beneficiaries, would like to purchase insurance against *all* medical costs including drug costs; however, at present, fee-for-service Medicare does not include a drug benefit, and Medicare beneficiaries have only limited access to drug benefits from other sources. Three of the ten standard Medicare supplemental insurance policies include some drug coverage, but these benefits are capped at \$1,250 or \$3,000 per year and this insurance is expensive, relative both to its actuarial value and to many potential buyers' incomes. Some beneficiaries have access to drug benefits via Medicare+Choice plans, but these plans are not available in all areas and may not appeal to all beneficiaries. Some beneficiaries have employer-provided retiree health insurance that includes drug benefits. Approximately one-third of seniors report having no drug coverage at all.

There are strong arguments for policy reforms that would increase Medicare beneficiaries' access to drug insurance and that would subsidize some of the costs of that insurance. Some evidence exists that a lack of drug coverage reduces access to essential drugs among the sickest patients and results in increased use of expensive institutional services, which *are* covered by Medicare and funded publicly.

The Pharmaceutical Research and Manufacturers of America (PhRMA) has retained Abt Associates to assess the viability of allowing the private sector to offer drug insurance for voluntary purchase by Medicare beneficiaries and enabling insurers to retain significant flexibility regarding how those benefits are designed. Private sector products could take various forms. A combination of government policies, presented below, could help to make the products affordable and to foster the success of these markets.

Advantages of Flexible, Privately-Provided Drug Benefits

Flexible, privately-provided drug benefits offer several potential advantages relative to their publicly-provided counterparts. Market competition would provide incentives for insurers to offer the best possible product at the best possible price; purchasers, voting with their pocketbooks, determine the design and generosity of their benefit. The private sector is free to adopt state-of-the-art utilization management techniques to the extent that purchasers are willing to accept them in return for the resulting reductions in premiums or cost-sharing. The private sector is also free to *negotiate* drug discounts with manufacturers; this is in contrast to government drug benefit programs which typically *mandate* drug discounts. Flexible, private benefits also allow ongoing innovation in areas such as the design of benefits, the techniques used to control costs, and special services for members; they enable Medicare beneficiaries to enjoy the same advantages as individuals with private insurance.

Adverse Selection: The Problem and Solutions

Any voluntary health insurance program faces the problem of adverse selection. At any given premium, individuals are most likely to purchase insurance if they expect their health costs (net of cost-sharing) to exceed the premium. This drives premiums higher, potentially creating a "death spiral" and provoking market collapse. Drug benefits may be particularly vulnerable to adverse selection, first because individuals can predict their expected drug costs more accurately than other components of their health expenditures, and second because the insurance policies under discussion will primarily be purchased by individuals, rather than groups. (Groups present less risk than individuals.) Also, the problem of adverse selection may discourage insurers from entering a newly opened market because the first market entrant is likely to attract the individuals with the greatest need for insurance, i.e. the highest expected costs.

Adverse selection may be exacerbated by flexible benefits. Flexible benefits further divide the market as each would-be purchaser selects the plan under which he would benefit the most. At the same time, insurers may try to structure benefits in such a way as to attract only low-cost or low-risk enrollees, that is, they will seek to avoid individuals with high expected expenditures, the very people in greatest need of drug insurance. This phenomenon is frequently referred to as "cherry-picking."

Adverse selection, however, can be substantially controlled by policies that 1) raise the total level of enrollment, 2) promote risk-neutral enrollment, and 3) keep premiums down. Subsidies to low-income buyers or to all buyers, possibly via favorable tax treatment, raise total enrollment and, by extension, lower the risk level in the enrolled pool. Such subsidies also extend access to individuals who might otherwise find drug insurance unaffordable. In order to minimize "crowding out," subsidies should probably be available to beneficiaries

regardless of whether their drug insurance comes from a former employer, a Medicare+Choice plan, a supplemental insurance program, or another insurance product.

To promote risk-neutral enrollment, insurers might be offered some latitude for underwriting. For example, all beneficiaries might be given a six-month enrollment window with guaranteed issue, with insurers able to impose reasonable restrictions after that. (This is the existing policy for Medicare supplemental insurance, and there are similar enrollment incentives in Medicare Part B.) To encourage significant enrollment, insured individuals should probably be guaranteed the ability to renew their policies annually at community rates following initial enrollment.

A high-risk pool or assigned-risk pool could also keep premiums down and mitigate the effects of adverse selection on the drug insurance market. Reinsurance, that covers a substantial share of any individual's annual drug expenditure in excess of a very high threshold, is an alternate policy with a similar impact. Such policies also soften insurers' incentives to engage in cherry-picking.

Reasonable standards for benefits is also a way to curb cherry-picking as well as to guarantee the quality of the products available. Benefits might be regulated along such dimensions as basis of premium and a requirement to cover at least some drugs in each of a set of standard therapeutic categories while leaving insurers latitude regarding formularies, utilization review, discounts, cost-sharing, pharmacy networks, and premiums. Reasonable requirements regarding when insurers could enter and exit this market and what populations must be served by participating insurers also "level the playing field," allowing markets to develop, and ultimately serve the interests of both potential insurers and potential purchasers.

Information/Protection for Purchasers

While adverse selection is the key issue for health insurance markets, concern is often expressed that individuals do not have sufficient knowledge of the different plans available to them to make well-informed decisions. The solution to this problem would entail helping Medicare enrollees select among competing plans, by requiring insurers to submit uniform information about the benefits they offer in clear, concise language. Third parties might also offer prudent purchaser information to help beneficiaries understand tradeoffs and make informed choices. Individuals eligible for coverage under the Federal Employees Benefits Program receive this kind of assistance today. The federal Office of Personnel Management requires that plans submit certain standard information that it compiles in a plan comparison book. Similarly, Washington Consumer Checkbook (a private consumer organization) publishes a more extensive annual guide to available plans for federal workers residing in or near Washington, DC.

Conclusion

In summary, there are strong arguments for extending Medicare beneficiaries' access to drug benefits. While all options should be discussed and explored, there are some clear advantages to a system in which the private sector offers a range of different competing plans and beneficiaries are free to choose among them. Such an approach would offer Medicare beneficiaries the opportunity to select the product that best suits their needs at a competitive price. The Medicare population would benefit from the ongoing innovation taking place in the national drug benefit market. The problems of adverse selection and, to a lesser extent, information/protection for purchasers certainly pose threats to the development and success of this market but these problems can be substantially controlled via a combination of policies. Such policies might include subsidies for low-income purchasers, favorable tax treatment, risk pools or reinsurance, reasonable regulation, and some latitude for underwriting, following an open enrollment period.

MANAGING RISK FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

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INTRODUCTION

A variety of proposals have been offered in Congress to increase access to prescription drugs for Medicare enrollees. Some believe that the pharmacy issue should be addressed only as part of comprehensive Medicare reform. Others, however, believe that comprehensive Medicare reform may take years to develop and implement, and believe that many seniors may be better served by an incremental approach that addresses the lack of access to prescription drugs with more immediacy.

This paper examines one aspect of an incremental approach by demonstrating how generally accepted actuarial techniques can be used to manage the risk of a prescription drug benefit offered through insurance companies. We believe these techniques can permit insurance companies to offer seniors financial security against high drug costs, and promote access to effective health care, while avoiding unnecessary or excessive utilization that can result from adverse selection.

FUNDAMENTALS OF PRESCRIPTION DRUG BENEFITS

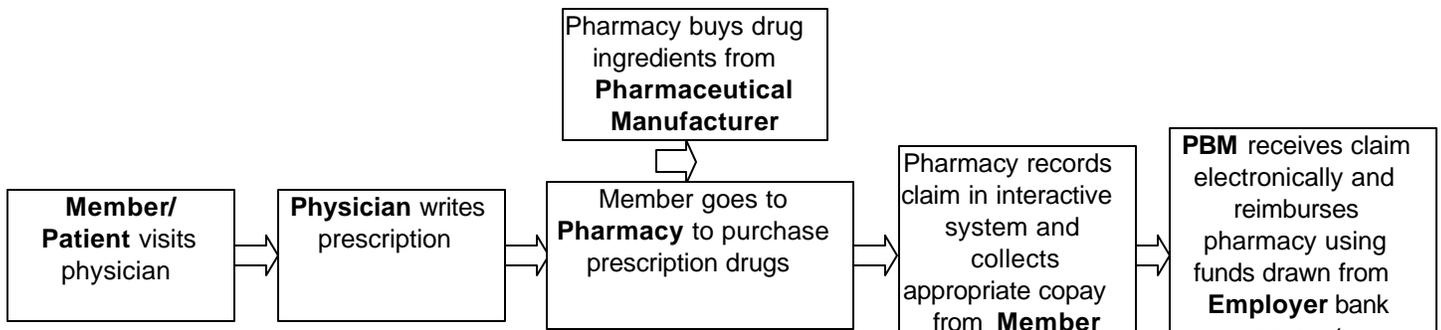
Before designing and pricing a health insurance product, an actuary usually seeks to answer several basic questions: how will health care services be approved and delivered, how much will services cost and what are the key drivers of utilization and cost. Taking a holistic approach enables the actuary to understand how the risk can be managed and thus improves the ability to predict cost and price the product appropriately (i.e., competitively yet sufficiently). This is a key step in risk management.

To frame our discussion, we must understand the major stakeholders and the mechanics of delivery for a prescription drug benefit.

The diagram below shows one example of how an insured patient obtains prescription drugs. Major stakeholders, shown in bold font, include the insured member (i.e., patient), physician, pharmacist, pharmaceutical manufacturer, insurer and pharmaceutical benefit manager (PBM).



In many large companies that self-fund their benefits (i.e., do not purchase insurance), a PBM administers the pharmacy benefit directly and reimburses the pharmacy once the covered employee or dependent has paid a copayment or coinsurance. This approach is shown below:



The actuary must also understand the key cost components and what is driving increases in these costs. Key cost components for a managed pharmacy program are shown below:

$$[(\text{Ingredient Cost} + \text{Dispensing Fee} - \text{Copay} + \text{Admin Fee}) * \text{Utilization}] - \text{Rebates} + \text{Drug-related Problems} + \text{Therapeutic Failures}$$

The administrative fee paid to the PBM or insurer generally covers the cost of on-line systems, electronic edits, customer service, pharmacy network contracting and maintenance, eligibility updates, communications, physician prescribing profiling and education, and drug utilization review. (A detailed discussion of these features is beyond the scope of this paper.)

The actuary is also interested in both short- and long-term cost trends. Drug expenditures have increased between 14.4 and 18.8 percent annually over the past three years and are expected to continue this level of increase over the next couple of years. The three major

components of prescription drug expenditures are: utilization, new products and elements, and price.

According to IMS Health, the main factors contributing to prescription drug spending in 1999 were non-price factors, including increased volume of prescriptions, record sales of new products, and the changing mix of available products being used. Of the 18.8 percent increase in drug expenditures (1999), 4.2 percent resulted from increased prices for existing drugs. The remaining growth was due to increased volume (10.8 percent) and new product introductions (3.8 percent).

Drug mix within a therapeutic class can change drastically as new, expensive but very effective drugs enter the market. Treatment thresholds are also lowered as these new drugs prove effective for larger groups of patients than in the past. And new drugs are being discovered to treat diseases for which no drug treatment was historically available.

With this basic understanding of prescription drug benefits, we can now begin to examine the risk management process.

FUNDAMENTALS OF RISK CONTROL

The objective of risk control is to reduce the frequency, severity or unpredictability of losses. There are numerous approaches to risk control e.g., risk avoidance, loss prevention, risk/loss reduction, risk separation, risk combination and contractual transfer of risk. In this paper we assume that most of the risk for prescription drug costs has been transferred to an insurer by purchasing insurance for a predetermined price (i.e., premium). The insurance company seeks to control or manage the risk using loss prevention and loss reduction techniques.

A key aspect of insurance is the pooling or spreading of risk. By pooling the risk for a large number of purchasers, the insurance company can improve the predictability of the average loss. By pooling risks, policyholders who have higher-than-expected losses are offset by those with lower-than-expected losses. The larger the pool, the better the predictability.

The improved predictability of large risk pools allows the actuary to establish reasonable premiums. Premium development is a critical function for insurers and involves determining a reasonable, yet sufficient, price for accepting the risk. In a competitive market, the insurer's rates must be attractive relative to the perceived value obtained by the purchaser.

In the premium development process, the actuary must consider factors that will have an impact on the risk, either positive or negative. The actuary must also estimate the probability of these factors occurring. For example, an insurer could reduce the risk of over-utilization of hospital services by implementing an inpatient pre-admission certification

program. The actuary would reduce the basic premium to reflect the expected reduction in hospital utilization due to this program.

ADVERSE SELECTION

Many factors can increase the level of risk for the insurer. One of the most significant of these is adverse selection. Adverse selection is defined as the tendency of purchasers, when given a choice of benefits, to choose the plan that will produce the greatest return to them for the price. When individuals are given choice, they will gravitate to the option that provides what they perceive as the best value for the amount they spend.

Although seniors cannot precisely predict their prescription drug needs for an upcoming year, they often have a good idea of whether these needs will be high or low. For example, a senior with a complicated heart condition and diabetes is likely to need far more prescription drugs than a senior who has no chronic conditions and exercises regularly.

When an insurer increases health insurance premiums to cover adverse selection, those in good health are likely to drop coverage, thus causing the average cost to increase for remaining members. If premiums are increased once again, the healthiest of the remaining members will also drop coverage. This creates an assessment spiral whereby premiums reach such a high level that only members with the worst health status remain.

In designing an insurance product, actuaries view the benefit cost as being composed of utilization multiplied by unit cost. For example, the cost for a prescription drug benefit would be equal to the number of prescriptions filled multiplied by the average cost per prescription. In applying risk management approaches, actuaries consider the impact that each will have on utilization, unit cost or both. Adverse selection is a key factor affecting utilization.

ACTUARIAL APPROACHES FOR MANAGING RISK

This section examines several risk management approaches used by actuaries in designing health care products. These techniques are used to prevent or reduce losses and to ensure the long-term viability of the product.

Law of large numbers – A key risk management approach is the spreading of risk using risk pools. Insurers understand that the average claims cost is significantly more predictable for larger groups of covered lives than for smaller groups since there is a greater probability of obtaining an average cross-section of risks. This approach is essential for managing the risk of a Medicare prescription drug benefit. Policies that

motivate a larger number of Medicare beneficiaries to choose a private insurance product will help to maintain a stable insurance market.

Premium sharing – Insurers typically require employers to contribute to the cost of group health insurance. The larger the percentage of cost contributed by the employer, the greater the participation, thereby reducing adverse selection. One of the most obvious ways to reduce adverse selection for a prescription drug benefit for Medicare beneficiaries is to have the federal government subsidize the cost for many seniors. This could be accomplished through direct payments to health insurers (e.g., similar to Medicare + Choice plans), tax credits or tax deductions. If individuals receive a substantial government subsidy (e.g., 25 percent or more of the cost), participation will be significantly greater than for a benefit that is wholly paid for by the beneficiary.

Risk-sharing – Insurers recognize that accepting 100 percent of the risk may eliminate any motivation that insured members have of helping control the risk. If, however, the insurer assumes 80 percent of the risk while members continue to pay 20 percent of the cost out of their own pockets, the member has significantly more motivation to control utilization and shop around for the best price. Risk-sharing has been used historically to control risk in health insurance and is applicable for prescription drug benefits as well. Many prescription drug plans use fixed copayments rather than percentage coinsurance so that members who must use high-cost drugs do not shoulder an inordinate burden. Copayments can also vary to provide incentives for patients to follow the most cost-effective drug therapies (e.g., generic, preferred brand, non-preferred brand).

Benefit design – Risk-sharing is one only aspect of benefit design. In addition to copayments and coinsurance, benefit provisions can also include deductibles, maximum benefit limits, internal limits, exclusions, coordination of benefits (see below), mandatory pre-certification for non-emergency high-cost care, and other cost-control incentives. The potential for adverse selection with respect to prescription drug benefits requires careful benefit design.

Individual underwriting and substandard premiums – The purpose of individual underwriting is to determine whether potential members are good or bad risks for the insurance company. Individual underwriting protects the insurer from providing coverage to a disproportionate number of unhealthy members. The worst risks are often declined coverage. Other potential members in bad health may be charged a substandard premium (i.e., a rate greater than the standard premium level). Individual underwriting can be performed using a short- or long-form questionnaire or by a physical examination by a physician.

Pre-existing condition limitations – Some health insurance policies exclude treatment for conditions that were treated during some time prior to coverage (e.g., six months). Pre-

existing condition limitations generally expire after coverage has been in effect for twelve months. The Medicare program does not currently include any pre-existing condition limitations.

High Risk Pools – Individual underwriting, substandard premiums and pre-existing condition limitations are all aimed at ensuring that insurers enroll a fair cross-section of risks. An alternative approach would be to establish high-risk pools to pick up risk that exceeds certain thresholds. These pools are essentially a reinsurance mechanism and could operate in several ways. One approach, commonly used in the auto insurance industry, is to have all insurers pay a certain premium to the pool for each of their enrolled lives. The pool would then pick up excess claims for any insured. For example, the government could fund a pool to cover the risk of prescription drug claims in excess of a certain threshold per individual per year.

Eligibility requirements – Health insurers often establish eligibility provisions to reduce the potential for adverse selection. For example, employees covered in a group health plan may need to be actively at work on the effective date of their insurance. This ensures that individuals are sufficiently healthy to be engaged in gainful employment. For those not actively at work, the effective date is deferred until they return to work. Similarly, the Medicare program charges higher premiums for seniors opt out of Medicare Part B upon initial eligibility and then choose to enroll at a later date.

Closed election periods – Requiring members to enroll only during a fixed election period each year, rather than having the opportunity to change benefits at any time, reduces adverse selection. A private insurance prescription drug program for Medicare beneficiaries should limit the frequency with which enrollees can change coverage. In addition, adverse selection could also be reduced by requiring seniors who opt out of coverage to wait at least two years before re-enrolling or to pay a premium surcharge (e.g., 10 percent) during the first two years after re-enrollment.

Coordination of benefits – Insurers typically coordinate coverage with other insurance or government-sponsored coverage such that benefits are reduced if another payor is primary. Coordination of benefits (COB) provisions would continue to be an effective way for insurers to ensure that seniors are not reimbursed for more than the costs they incur. COB would also provide some cost savings for insurers.

Premium development – Careful premium development with appropriately established risk margins is another approach for controlling risk. For example, tiered rating might apply for benefits that vary significantly with age or certain other factors (e.g., whether a senior is a smoker or a non-smoker). Durational rating might be applied to reflect expected select and ultimate claims costs.

Links to other coverage – To reduce adverse selection, some health insurers have packaged together various benefits. For example, packaging vision benefits with medical benefits avoids the high adverse selection that results when only those who need glasses or contact lenses purchase vision coverage. Medicare + Choice plans are likely to combine prescription drug options with medical options to reduce adverse selection. An integrated approach to managing the health care of seniors is significantly more effective than a fragmented approach and can produce significant savings over the long term.

Risk-adjusted premiums – Risk adjusters are designed to provide higher payments to those insurers who enroll individuals who are more likely to have higher costs. For example, HCFA has proposed reimbursing Medicare + Choice plans on a risk-adjusted basis that would pay more to plans that enroll individuals with diagnoses that are projected to produce higher medical costs. Risk-adjusted premium subsidies from the federal government for prescription drug coverage would be one solution for ensuring that insurance companies that enroll a high proportion of high-cost seniors for the same average premium as competing insurers do not bear an unfair burden.

Reducing the number of options – Giving potential enrollees a choice among benefits, options or financial terms can lead to adverse selection. High benefit users will tend to choose options that provide more generous coverage whereas low benefit users will choose low-cost, less generous coverage. Insurers can reduce adverse selection by reducing the number of options. The number of prescription drug options for seniors can be limited (much like Medigap plan options) thereby reducing chances of adverse selection and facilitating comparisons among companies. Alternatively, an independent Board could be established to certify that plans meet certain minimum criteria. This would reduce the variability among plan designs and also the potential for adverse selection.

Marketing rules – Although Medicare + Choice plans are offered through the private market, the government has instituted uniform rules that level the playing field for competitors. These rules not only prevent discriminatory marketing but also ensure that all competitors have a fair chance of enrolling an average cross-section of risks. Similar rules could be considered for prescription drug plans to reduce opportunities for “cherry picking.”

SOME FINAL WORDS

The actuarial design features described above are used to improve an insurer's ability to manage risk. Given the potential for adverse selection among insurers and the importance of ensuring the long-term viability of a private market Medicare prescription drug program, these techniques should be carefully considered. Good and accurate data can also help to

reduce insurance costs. The impact of each approach used should be continuously monitored to measure its value.

This paper has briefly described some approaches that insurance companies can use to control risk for prescription drug benefit coverage. While designing a market-based prescription drug benefit would require careful design, there are private-market solutions that work.

TYPES OF INSURANCE

There are many varying types of insurance coverage available in the United States. Coverage can range from the typical health and auto insurance, to the more unusual, including insurance for a dancer's legs or a doctor's hands. If a client is willing to pay, there are few limits to the types of insurance coverage available.

Listed below are a number of insurance products ranging from health to weather conditions.

Health Insurance

- Critical Illness Insurance
Cancer, heart disease, etc.
- Critical Security Insurance
For those suffering from a critical illness
- Children's Insurance
- College Students' Health Insurance
- Emergency Room Insurance
- Catastrophic Disability Insurance
- Infertility Coverage
- Pregnancy Complication Insurance
- Hospital Indemnity Insurance
Covers hospital confinement and ICU
- Campers Accident & Sickness Insurance
- "Specified Diseases" Insurance
E.G. stroke, diabetes, HIV
- Pre-Schooler Accident Insurance
- Sports Accident Insurance
- Psychiatric Insurance
- "Natural Health Supplemental Insurance"
Covers acupuncture, homeopathy, Oriental medicine, nutritional counseling, biofeedback, colon therapy, etc.

Horse Related Insurance

- All Breeds
National and International)/All Disciplines
- Animal Mortality*
National and International
**(Horses, Mules, Donkeys, Dogs, Ostrich, Sheep, Pigs, Goats, Llamas, Exotics, to name a few.)*
- Associations
- Auto
- Barns
- Barrel Racing
- Bed and Breakfasts (Inns)
- Blacksmiths
- Boarding
- Boats
- Breeding
- Business Packages
- Care, Custody and Control
- Carriage Rides
- Clinics
- Combined Training
- Commercial Farm Auto
- Commercial Horse Liability
- Commercial Packages
- Cutting
- Dairy Farms
- Draft Horses
- Dressage
- Drill Teams
- Driving
- Dude Ranches
- English
- Equine Dentists
- Equitation
- Eventing
- Farm Machinery
- Farms

TYPES OF INSURANCE

- Farriers
- Flood
- Fox Hunters
- Gaited Horses
- Gymkhanas
- Harness Horses
- Hay Rides
- Horse Haulers
- Horse Owners
Private Liability
- Horse Shows
- Horse Trailers and Vans
- Hunters
- Instructors Liability
- Jumping Horses
- Leased Horses
- Liability, Commercial and Personal
- Livestock
- Major Medical
- Marinas
- Miniature Horses
- Mounted Troops
- Orchards
- Personal Auto
- Personal Liability
- Personal Umbrella
- Pleasure Animals
- Ponies
- Pony Party Liability
- Race Horses
- Race Horse Liability
- Reining Horses
- Restaurants and Taverns
- Riding Lessons
- Riding Stables - Public and Private
- Roping
- Saddle Shops
- Saddleseat
Both International and National
- Sales Barns
- Shipping
- Sleigh Rides
- Sport Horses
- Sports Accident Coverage
- Stables
Public and Private
- Steeplechasers
- Stock Horses
- Student Accident Coverage
- Tack Shops
- Tack and Equipment
- Team Penning
- Three Day Eventing
- Trail Rides
- Trailers
- Transport
National and International
- Trotters
- Truckers
- Truckers General Liability
- Vans
- Vaulting
- Vet Clinics
- Veterinarians
- Vineyards
- Workers Compensation

Weather Insurance

(covering hurricane, typhoon, rain, snow, wind, hail, etc.)

- **Special Events:** Fairs, Festivals, Airshows, Fourth of July, Chambers of Commerce, Parties, Weddings, Fireworks, Parades, Fundraisers, Company Outings, Conventions, Carnivals, Picnics, Hospitality, Theatrical Productions
- **Concerts:** Amphitheater, Promoters, Venues, Concessions, Sheds/Shacks
- **Sports:** Racing, Football, Baseball, Mud Racing, Basketball, etc.
- **Entertainment:** Commercials, TV Shows, Film/Video Productions, Photo Shoots, Advertising

TYPES OF INSURANCE

- **Promotions:** Car Dealers, Jewelry Stores, etc.
- **Agricultural:** Fruit/Vegetable growers, Packers, Canneries, Juicers, etc.
- **Snow Removal:** Municipal, Towns, School Districts, Airports, Universities, etc.
- **Weather Sensitive Business:** Resorts, Country Clubs, Florists, Ski Resorts, Utilities, Flea Markets, etc.

Marine Insurance

- Private Pleasure Craft
- Boat Dealers
- Piers, Wharves, and Docks
- Charterers Legal Liability
- Marina Operators
- Passenger Vessels