The ultimate effects of the reform will be broad reaching across many stakeholders. It will take interdisciplinary teams working in concert to meet the challenges ahead. Employers, insurance companies and managed care plans, vendors, insurance brokers and consultants, federal, state and local governments, and the health care industry itself, as well as all of us as the recipients of health care services recognize the diverse and difficult challenges ahead. However diverse, all must acknowledge that the decisions made in response to the reform must be based on reining in health care spending while improving the quality of the care delivered. Regardless of the ultimate outcome of the reform, the health care industry is in a period of transformation identifying new systems of care that will lower costs and improve quality and patient safety.

Health care reform and the transformation of the health care industry provides employers with an unparalleled opportunity to reassess their health care benefit strategy making sure it is consistent with the requirements of health care reform and also the long-term strategy of their organization.

According to the “16th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care,” employers expect average costs for employee health benefits to increase 7% in 2011, up from an increase of 6% in 2010. The survey further indicates, to mitigate costs, employers are redefining their financial commitments to health benefits by redesigning programs to incorporate enhanced point of care treatment, positioning incentives more aggressively and redefining the employee vs. dependent subsidy.

**Among other survey findings:**

- Rising health care costs and the potential financial impact of health care reform are leading more than half of employers to enhance their efforts to engage employees in actively managing their own health.

- Employers’ commitment to providing health care benefits for active employees remains strong. However, health care reform could accelerate a growing employer exit from retiree medical programs.
employers with “rich” medical employee benefit plans will be subject to the Cadillac tax: a non-deductible excise tax of 40% levied on the annual value of health insurance costs for employees that exceed $10,200 for individual coverage or $27,500 for family coverage.

While the law is complex and many areas are as yet undefined, employers working together with the many other stakeholders are at a unique crossroads to transform the way health care services are financed and delivered. In September of 2010, six of the law’s provisions formally took effect. These provisions support greater access to health coverage and improvements to benefits and provide more consistency in what is offered across the country. They include dependent coverage to age 26, changes to the way preventative services are reimbursed, elimination of lifetime limits, elimination of pre-existing condition exclusions for children and better access to emergency and obstetric and gynecology services.

The health care reform law has the potential to improve the lives of the U. S. population in important ways. Regardless of the ultimate outcome of the legislation, stakeholders are moving forward to transform the way health care is financed and delivered and guide change that will go on for decades. As the primary provider of health care benefits to a large portion of the population, employers will play a critical role in steering the future of American health care.


To curb health benefit costs, employers are turning to consumer-driven health plans that combine high deductibles with either a health reimbursement arrangement or a health savings account.

Employers are encouraging vendors to coordinate care, implement evidence based treatments, and use emerging technologies aimed at improving quality and efficiency.

80% of the respondents expect the “Cadillac tax,” which imposes an excise tax in 2018 on expensive health insurance plans, will have some impact on the health care strategy for active employees.

Organizations will also continue to focus on activities that encourage healthier employee lifestyles and behaviors as well as an increased emphasis on preventative services.

The affect of the new law on employers will differ depending on their size and whether they currently offer health insurance to their employees. Small organizations with less than 50 full-time employees will face no new employee insurance requirements, but will have new insurance alternatives available to them through state-based Small Business Health Options Program (SHOP) exchanges. While the law does not require small employers to contribute toward their workers’ health insurance costs, the law does provide tax credits for some small employers to maintain or begin offering coverage to their employees. These tax credits will offset a portion of the purchase of health insurance by low-wage employers with 25 or fewer employees. Small employers will continue to have the ability to purchase coverage in the small group market as they do today.

Medium-size employers with 50-100 employees will have the option to purchase coverage through the SHOP exchanges as well as traditional insurance and managed care options. The vast majority of employers with more than 100 employees currently offer insurance to their employees in some manner, however there are provisions in the law that will affect large employers’ coverage and costs.

Employers with 200 or more full-time employees that currently offer medical insurance will be required to automatically enroll all full-time employees and all previously enrolled employees into a plan each year. However, employees will have the option to “opt out” of the plan if they so desire. Many employers have yet to decide whether they will continue to offer coverage options in 2014 when the Universal Health Care requirement goes into effect, or pay the annual $2,000 per employee assessment for not providing coverage. In addition, in 2018 large employers with “rich” medical employee benefit plans will be subject to the Cadillac tax: a non-deductible excise tax of 40% levied on the annual value of health insurance costs for employees that exceed $10,200 for individual coverage or $27,500 for family coverage.

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*Hold it—we almost forget his benefits package.*
The Federal Insurance Office: Relevant? Only Time Will Tell

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The Federal Insurance Office (FIO), created under the Dodd-Frank financial reform law,1 has the potential to put the U.S. in the lead to redesign the insurance industry on a global basis. The FIO reflects Congressional concern that the current U.S. state-based system of insurance regulation lacks uniformity and is not equipped to respond to events - domestic or international - that are transformational in nature and have the potential to significantly impact the U.S. and global insurance industry. Reacting to threats that U.S. reinsurance collateral rules create unfair trade barriers for foreign insurers and the emergence of concerns about “systemic risk” following AIG’s federal bailout in 2008 and its impact on the global insurance market, the U.S. Congress responded by creating the FIO. The FIO has an enormous opportunity to create a blueprint for the modernization of the U.S. state-based insurance regulatory system that could allow U.S. insurers and reinsurers to better compete in the global marketplace.

The FIO clearly could pave the way for substantive changes to the U.S. rules-based system of insurance regulation. Many believe that a rules-based regulatory system is much less dynamic and practical than a principles-based or “prudential” regulatory system similar to that which exists in the EU and other significant foreign insurance jurisdictions, such as Switzerland and Singapore. The broad scope of change that is possible is largely derived from the FIO’s strong data collection powers and strict reporting requirements which are aimed at providing the House and Senate2 with a critical assessment of the U.S. and global reinsurance market. The scope of this assessment is to include international coordination of insurance regulation, as well as recommendations on how to modernize and improve U.S. insurance regulation for all lines of insurance, except health, crop and long term care (unless it has life or annuity components).

The FIO, which reports to the U.S. Treasury Secretary, is also engaged in coordinating efforts to develop federal policy on international insurance matters of a prudential nature. The FIO is designated to assist the Treasury Secretary in negotiating agreements with foreign governments or regulatory authorities. In this regard, the FIO has the authority and responsibility for determining whether a state insurance measure is more favorable to U.S. insurers than to a non-U.S. insurer based in a jurisdiction that has entered into a “covered agreement”3 with the U.S. and is inconsistent with the terms of that covered agreement. It is important to note, however, that the FIO has no authority to preempt state measures on rates, premiums, underwriting or sales practices, coverage requirements, application of anti-trust laws or capital or solvency measures (unless such measures are more favorable to U.S. insurers). However, it is empowered to monitor systemic risks that could lead to a crisis in the insurance industry or the U.S. financial system, among other things.4

In March 2011, Timothy Geithner, U.S. Treasury Secretary, announced the appointment of Michael McRaith, Illinois’ former chief insurance regulator and the NAIC’s current secretary-treasurer, to be the Director of the FIO. While McRaith’s appointment is seen as a positive development by the U.S. insurance industry because of his strong credibility among state regulators, it is still too early to tell whether the FIO will eventually gain momentum and be recognized with the status of a federal agency. The potential accomplishments of the FIO could be somewhat derailed by the possibility of legal challenges raised by parties contending that these laws are ambiguous, particularly with respect to the FIO’s role regarding preemption determinations and protecting disclosures of information obtained from its data collection authority. The FIO’s data gathering and reporting obligations are extensive, but it remains to be seen if the FIO will receive adequate funding and staffing to effectively carry out its international mandate and assessment of U.S. insurance regulation. Time will tell whether the FIO is up to the job or much ado about nothing. 

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2 The Committee on Financial Services of the House and the Committee on Banking, Housing and Urban Affairs of the Senate. See 31 U.S.C. Sec. 313(o).
3 A Covered Agreement means “a written bilateral or multilateral agreement regarding prudential measures with respect to the business of insurance or reinsurance...” See 31 U.S.C. Sec. 313(i)(2). Covered Agreements must: (i) be entered into between the U.S. and one or more foreign governments, authorities, or regulatory entities, and (ii) relate to the recognition of (re)insurance prudential measures that achieve a level of protection for (re)insurance consumers that is substantially equivalent to the level of protection achieved under U.S. state-based (re)insurance regulation. Id.
4 See 31 U.S.C. Sec. 313(o).
In the cyber-world, huge expenses can be incurred before a data breach even reaches the point when a claim could be made. There are forensic costs to identify and investigate the source of the breach; statutory penalties when state and federal laws are violated; and costs for customer notification, credit monitoring, and identity restoration. Later, at the claim stage, companies having had cyber attacks will likely face the expenses of lawsuits and government investigations. Business losses can occur at all stages. According to the Ponemon Institute study\(^1\), which examined the 2010 costs of data breaches of 51 U.S. companies in 15 different sectors, the average cost per company was $7.2 million per breach, with the most expensive data breach costing $35.3 million and the least expensive breach costing $780,000.

Traditional commercial general liability, business owners and property damage policies typically do not provide the necessary coverage, and in many instances, insurers have expressly excluded coverage for data breaches and the resulting array of damages that may be incurred.

Increasingly, businesses of all sizes and in all industries are turning to first-party and third-party cyber liability insurance to protect their tangible and intangible assets. The need is not limited to e-tailers and other e-commerce based businesses. Traditional retailers, the health care sector, middle-market and small companies, or for that matter any company that uses the internet for sales or marketing, should consider cyber insurance or technology errors and omissions insurance to provide network security and privacy breach coverage. Every business should consider assessing their potential cyber exposures as these risks have no boundaries or limits.

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\(^1\) 2010 U.S. Cost of a Data Breach, The Ponemon Institute, March 8, 2011.