



Legislative & Regulatory Report

NATIONAL ALLIANCE OF LIFE COMPANIES *An Association of Life and Health Insurance Companies*

March 2011 Edition

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The news in this publication, including links to background and supplemental information on state websites, is available on the NALC members website at <http://members.nalc.net>.

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Arkansas

Publication of NAIC Accounting Practices and Procedures Manual (Bulletin 1-2011)

The Arkansas Insurance Department has sent this bulletin as notification of the Commissioner's intent to adopt the amendments, revisions, or modifications to the Accounting Practices and Procedures Manual as of March, 2010, published by the National Association of Insurance Commissioners ("NAIC").

This notice is required by Ark. Code Ann. § 23-63-613 to allow the Commissioner to specify that domestic insurers and other domestic reporting entities shall use the most recent 2011 edition of APPM, no sooner than eight (8) months after distribution of the required statutory notice.

Therefore, please be advised that the effective date for the prescribed use of the Accounting Practices and Procedures Manual as of March, 2011 for Arkansas domestic reporting entities shall be for the Annual Statement as of December 31, 2011, to be filed with this Department on or before March 1, 2012.

The address for the NAIC web site is www.naic.org, or you may place your orders with the NAIC Insurance Product and Services Division at prodserv@naic.org or by calling the NAIC Products and Services Division at (816) 783-8300.

Questions concerning this Bulletin should be directed to Mel A. Anderson, Deputy Commissioner - Finance Division, at (501) 371-2665 or via e-mail to mel.anderson@arkansas.gov. The complete bulletin is available at <http://www.insurance.arkansas.gov/Legal%20Dataservices/PCBulletinYR.htm>.

Connecticut

Use of Retained Asset Accounts (Bulletin IC-27)

The purpose of this bulletin is to establish disclosure standards regarding the payment of life insurance to a beneficiary by means of a "Retained Asset Account." "Retained Asset Account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account, with check or draft writing privileges, or through the use of a debit card or other similar instrument upon which the proceeds may be drawn, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits. Insurers are expected to implement these standards no later than 90 days from the date of this bulletin. [By statute, an insurer is defined as "any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society..." Conn. Gen. Stat. §38a-1 (11)]

Section 1. Explanation of Settlement Options

The insurer shall provide the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the options.

Section 2. Supplemental Contract

If the insurer settles benefits through a Retained Asset Account, the insurer shall provide the beneficiary with a supplemental contract, before the account is selected, that clearly discloses the rights of the beneficiary and obligations of the insurer under the supplemental contract.

Section 3. Disclosures for Retained Asset Accounts to Beneficiaries

The insurer shall provide the following written disclosures to the beneficiary before the account is selected:

- A. Payment of the full benefit amount is accomplished by delivery of the “draft book,” “checkbook” or similar instrument.
- B. One draft or check may be written to access the entire amount, including interest, of the Retained Asset Account at any time.
- C. Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the insurer’s minimum balance requirements.
- D. A statement identifying the account as either a checking or draft account and an explanation of how the account works.
- E. Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services.
- F. A description of fees charged, if applicable.
- G. The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity.
- H. The minimum interest rate to be credited to the account and how the actual interest rate will be determined.
- I. The interest earned on the account may be taxable.
- J. Retained Asset Account funds held by insurance companies are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) , but may be guaranteed by the state life and health insurance guaranty associations. The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations to his or her account
- K. A description of the insurer’s policy regarding Retained Asset Accounts that may become inactive.

The bulletin is available at <http://www.ct.gov/cid/cwp/view.asp?Q=254262&A=1255>.

Iowa

Use of Retained Asset Accounts (Bulletin 11-01)

The Iowa Insurance Commissioner has released a bulletin similar to the one from Connecticut (see above). It is available at http://www.iid.state.ia.us/news_media/bulletins.asp. The following introductory paragraphs differ from those in the Connecticut bulletin.

The purpose of this bulletin is to establish disclosure standards regarding the payment of life insurance benefits to a beneficiary by means of a “retained asset account.” “Retained Asset Account” means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits. This bulletin does not apply to fraternal benefit societies.

When a life insurer uses a retained asset account, as defined above, the life insurer must provide additional disclosures as detailed below. Life insurers are not required to file their proposed disclosure forms with the Iowa Insurance Division. Life insurers should be prepared to demonstrate compliance with this bulletin for all claims made on or after May 1, 2011.

Many other states have issued similar bulletins, with more to come.

Michigan

Bulletins

The following bulletins issued by the Michigan Office of Financial and Insurance Regulation. They can be found at http://www.michigan.gov/dleg/0,1607,7-154-10555_12900---,00.html.

Maximum amount of the Cemetery or Funeral Assignment under the Michigan Insurance Code (Bulletin 2011-06-INS)

This bulletin supersedes Bulletin 2010-11-INS, dated May 26, 2010.

Section 2080 of the Insurance Code, 1956 PA 218, MCL 500.2080, allows a life insurer to write a life insurance policy or annuity contract which is subject to an assignment of the proceeds of the insurance policy or annuity contract as payment for cemetery services or goods, or funeral services or goods. Under Section 2080(g), MCL 500.2080(g), the maximum death benefit of an associated life insurance policy or annuity contract which is subject to the assignment is \$5,000 when the first premium payment is made; and in the case of a non-associated life insurance policy or annuity contract, the maximum initial amount of proceeds assigned shall not exceed \$5,000. Both amounts shall be adjusted annually, in accordance with the consumer price index.

The new cemetery/funeral maximum assignment effective June 1, 2011 through May 31, 2012 is \$9,466. The maximum assignment levels for recent years are as follows:

June 1, 2010 through May 31, 2011	\$9,393
June 1, 2009 through May 31, 2010	\$9,450
June 1, 2008 through May 31, 2009	\$9,238
June 1, 2007 through May 31, 2008	\$9,072
June 1, 2006 through May 31, 2007	\$8,808
June 1, 2005 through May 31, 2006	\$8,560

CPI-Adjusted Return Check Charge: Deferred Presentment Service Transactions (Bulletin 2011-04-CF)

Section 2158 [(Sec.38(3))] of the Deferred Presentment Service Transactions Act, 2005 PA 244, MCL 487.2158, allows licensees to adjust the maximum returned check charge by an amount determined by the commissioner. The current returned check charge of \$25.00 is the maximum amount a licensee may contract for and collect if the drawer's check that the licensee is holding in a deferred presentment service transaction is returned by the drawee due to insufficient funds, a closed account, or a stop payment.

The maximum charge of \$25 for returned checks is to be adjusted every fifth year on and after March 1, 2011, to reflect the percentage change in the Detroit Consumer Price Index (CPI) for the five preceding calendar years.

This is to inform you that the Commissioner of the Office of Financial and Insurance Regulation has performed the required CPI review, and for the five-year period ending December 31, 2010, the maximum returned check charge under Sec. 38(3) of the Deferred Presentment Service Transaction Act is adjusted from \$25.00 to \$26.88.

New Jersey

False Advertising and Defamation (Bulletin 11-01)

N.J.S.A. 17B:30-4 prohibits life and health insurers and producers from making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated,

circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance and annuities or with respect to any person in the conduct of his insurance and annuity business which is untrue, deceptive or misleading.

N.J.S.A. 17B:30-7 prohibits life and health insurers and producers from making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance or annuity.

Health insurers and producers are also subject to N.J.A.C. 11:2-11.10, which provides that advertisements shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services or business methods, and to N.J.A.C. 11:2-11.17, which prohibits advertisements from containing statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age or relative position in the insurance business.

Similarly, life insurers and producers are subject to N.J.A.C. 11:2-23.6 (o), which proscribes the same content in their advertisements that is prohibited by N.J.A.C. 11:2-11.10. Pursuant to N.J.A.C. 11:17A-3.1, to the extent that they regulate the conduct of producers, property and casualty producers are also subject to these rules concerning life and health insurance advertising.

The Department has recently received a number of complaints regarding advertisements and is issuing this Bulletin to provide guidance to life and health insurers and producers, and further guidance to property and casualty insurers and producers, as to content and/or omissions that the Department considers to be prohibited by the statutes and rules cited above. The Department intends to propose regulations to codify the guidance set forth herein.

The Department believes that the above-referenced authorities require that in advertisements that make express or implied claims that are likely to be misleading in the absence of certain qualifying information, such qualifying information shall also be disclosed in the advertisement, and done so in a clear and conspicuous manner. For example, an advertisement that identifies an insurer's competitors and states that those competitors are not rated by certain rating agencies, or are not rated, will be considered to be actionable if the advertisement does not also disclose whether or not the advertising insurer has such a rating or is not rated. Similarly, the Department construes these laws and rules to require that if an advertisement includes financial information of competitors, such as surplus, assets or premium, the same information must be presented for the advertising insurer.

Life and health insurers and producers whose advertisements are found to be in violation of N.J.S.A. 17B:30-4 or 17B:30-7 or the rules referenced above will be subject to penalties as provided in N.J.S.A. 17B:30-17 and 30-20.

Insurers are encouraged to disseminate this Bulletin to all producers with whom they have agency contracts. The bulletin is available at <http://www.state.nj.us/dobi/bulletin.shtml>.

New York

Disaster Planning, Preparedness and Response

Circular Letter No. 2 (2011)

This circular letter replaces and repeals Circular Letter No. 2 (2010). Disaster planning, preparedness, and response for life insurers and property/casualty insurance industries are covered by separate circular letters.

The letter is nine pages long, and includes a table of contents with the following topics:

- Organization of this Circular Letter
- The New York State Insurance Disaster Coalition and Insurance Emergency Operations Center (IEOC)
- Before a Disaster Strikes
- Disaster Response Plan and Questionnaire
- Business Continuity Plan Questionnaire
- Operations During a Disaster
- Insurance Company Disaster Liaisons
- Liaison Duties and Responsibilities
- After a Disaster
- Post Disaster Coverage Data and Loss Statistics
- Miscellaneous Items
- Confidentiality
- Communications Network

Questions concerning any aspect of this circular letter should be directed to Principal Insurance Examiner Vincent Mazzarella, Emergency Management Coordinator, by phone at (212) 480-5440, by e-mail to vmazzare@ins.state.ny.us, or by mail to State of New York Insurance Department, Emergency Management Coordinator, 25 Beaver Street, New York, NY 10004.

The complete letter is available at <http://www.ins.state.ny.us/circltr/2011.htm>.

Guaranteed Minimum Withdrawal Benefits and Excess Withdrawals Under Annuity Contracts

Circular Letter No. 5 (2011)

The purpose of this Circular Letter is to advise insurers that an insurer should provide an annuity contract owner with a disclosure notice that explains the impact of an excess withdrawal on the annuity contract's guaranteed minimum withdrawal benefit ("GMWB").

A GMWB provides for the continuation of guaranteed withdrawal amounts regardless of the amount of value remaining in an annuity contract. However, a GMWB generally provides for a reduction in future guaranteed minimum withdrawal amounts if the contract owner withdraws money in excess of the guaranteed withdrawal amount. The reduction in future amounts is typically made on a proportional basis, where the reduction equals the guaranteed withdrawal amount times the ratio of the excess withdrawal amount to the account balance (after the reduction for the withdrawal benefit, but prior to the excess withdrawal). As a result, the reduction in the guaranteed withdrawal amount may be disproportionate compared to the excess withdrawal amount.

For example, when the guaranteed minimum withdrawal amount is \$100 and the contract owner withdraws \$180, the excess withdrawal amount is \$80 (\$180-\$100). Assuming the value of the annuity contract is \$500, the guaranteed minimum withdrawal amount would reduce the value of the annuity contract to \$400 (\$500-\$100). The excess withdrawal amount further reduces the value of the annuity contract to \$320 (\$400-\$80).

The excess withdrawal results in a permanent reduction of the annual guaranteed withdrawal amount by 20% (80/400) to \$80 per month.

Indeed, if the value of the annuity contract before any withdrawal had been \$200 instead of \$500, the percentage reduction would have been 80% (80/100), permanently reducing the guaranteed withdrawal amount from \$100 to \$20. As a result, the contract owner would be giving up guaranteed \$100 payments for life because he or she requested a one-time additional \$80 withdrawal. If the contract owner chooses to surrender the annuity contract, the guaranteed withdrawal benefit would be eliminated.

The Department recognizes that insurers need to limit their exposure to possible anti-selection for annuity contracts with GMWBs and that proportional reductions are a common way of limiting this exposure. The Department also recognizes that contract owners who are terminally ill or otherwise have a reduced life expectancy may have an immediate need to access their funds, which is of greater importance than preserving their future life contingent payments. However, proportional reductions may result in reductions in the guaranteed withdrawal amount that are disproportionate to the excess withdrawal amount or the amount received for a full surrender. In order to make an informed decision as to whether to take an excess withdrawal, contract owners need disclosures that explain the impact of excess withdrawals on the guaranteed withdrawal amount.

Accordingly, the Department expects insurers to provide disclosures: (1) in the annual or other periodic statement sent to a contract owner; and (2) at the time that a contract owner requests an excess withdrawal. The disclosure should clearly explain the effect of taking an excess withdrawal. A general explanation is acceptable if it also indicates that the contract owner may request a personalized, transaction-specific calculation showing the effect of the excess withdrawal as of the close of the previous business day, and what the guaranteed withdrawal amount would have been if the contract owner had taken the excess withdrawal. The Department would find the following sample disclosure acceptable:

Withdrawals in excess of the guaranteed withdrawal amount, called “excess withdrawals”, will result in a permanent reduction in future guaranteed withdrawal amounts. If you would like to make an excess withdrawal and are uncertain how an excess withdrawal will reduce your future guaranteed withdrawal amounts, then you may contact us prior to requesting the withdrawal to obtain a personalized, transaction-specific calculation showing the effect of the excess withdrawal.

The Department recognizes that the manner in which an insurer provides the disclosure at the time of request will vary depending upon the way in which the contract owner requests the excess withdrawal. For example, insurers often accept withdrawal requests by administrative request form, telephone or over the internet. The Department expects that an insurer will provide the disclosure on its withdrawal request form if a contract owner uses such a form to make a request. If a contract owner makes a request through the internet, then the Department expects an insurer to provide the disclosure through the internet. If a contract owner makes a request by telephone, then the Department expects an insurer to provide disclosure to the contract owner orally over the telephone. Other methods of providing the disclosure at the time that a contract owner makes an excess withdrawal request may be appropriate depending upon the method by which a contract owner may request an excess withdrawal from an insurer. An insurer should establish protocols and maintain accurate records to verify that the notices are so provided. The Department recognizes that the time limitations imposed by federal securities law for processing withdrawal requests may hinder an insurer’s ability to provide the disclosure if it receives a written letter requesting the excess withdrawal. If a contract owner requests an excess withdrawal by written letter, an insurer should make a good-faith effort to provide the disclosure.

With respect to group annuity contracts issued to employee benefit plans as defined in the Employee Retirement Income Security Act of 1974 (“ERISA”), insurers should advise employers or plans that appropriate disclosure to individual participants may be required.

Insurers should implement the disclosure discussed herein within 90 days of the date of this Circular Letter. Please direct any questions regarding this Circular Letter to Todd Cafarelli, Senior Insurance Attorney, Life Bureau, at (518) 474-4552 or by email at tcafarel@ins.state.ny.us.

The complete letter is available at <http://www.ins.state.ny.us/circltr/2011.htm>.

South Dakota

Notice of Public Hearing to Adopt Rules

A public hearing will be held in the Main Floor Conference Room, Anderson Building Pierre, South Dakota, on March 17, 2011 at 10:00 a.m., to consider the adoption and amendment of proposed rules to the following:

Chapter 20:06:18 - The effect of the rules is to change the time extension associated with continuing education requirements. The reason for adopting the rules is to correct an erroneous cross reference.

Chapter 20:06:21 - The effect of the rules is to require agents to complete application and replacement forms for long term care policies. The reason for adopting is to ensure agents are properly asking and recording answers on application and replacement forms.

Interested person may send comments to Melissa Klemann at melissa.klemann@state.sd.us. The rules are available at <http://www.state.sd.us/drr2/reg/insurance/Legal/hearing.htm>.