

## INSURANCE LAW ALERT

APRIL 2009

### Individual Fixed Deferred and Immediate Annuity Form Filing and Suitability Notice Requirements

As noted in Department Bulletin No. 09-06 (March 9, 2009) ([http://www.state.nj.us/dobi/bulletins/bltog\\_06.pdf](http://www.state.nj.us/dobi/bulletins/bltog_06.pdf)), Public Laws of 2008, Chapter 88 (the "Act") was approved on September 19, 2008 and became effective on April 1, 2009. The Act provides marketing, information disclosure and product suitability requirements for all current and future issues of individual fixed deferred and immediate annuity contracts solicited directly to consumers. Among other things, the Act requires the Commissioner to approve an annuity buyer's guide and standard form of an annuity contract disclosure statement to be used by an insurance agent or insurer in the solicitation, negotiation or sale of an annuity. The Act further requires those selling these products to make reasonable efforts to obtain and record information about the suitability of the product for the solicited consumer and the consumer's acknowledgement of the information recorded.

In Bulletin No. 09-06, the Department advised insurers of the Act's requirements and provided guidance on compliance. The Department has since received comments and questions about the Act and the prior Bulletin, some of which are of general interest to insurers. Accordingly, the pending Bulletin (No. 09-12) ([http://www.state.nj.us/dobi/bulletins/bltog\\_12.pdf](http://www.state.nj.us/dobi/bulletins/bltog_12.pdf)), is being issued to further clarify the Department's interpretation of the applicability of the Act. While the earlier Bulletin remains in full force and effect, please consider the following a supplemental explanation of the requirements of the Act, which were effective April 1.

Until the Department has adopted approved rules, it will be impossible for insurers to distribute or make available to their consumers so-called "approved" versions of the annuity contract disclosure statement and the buyer's guide. Thus, until the rules are in effect, the Department will agree that the free-look provisions, buyer's guides and disclosure statements that are included in or accompany an individual fixed deferred and immediate annuity form provided to consumers should contain the provisions required by the Act and those detailed in the prior Bulletin (No. 09-06).

#### A. Suitability Notice

As is indicated in Bulletin No. 09-06, the suitability notice must be prescribed by, but does not require approval of, the Commissioner. Until rules are adopted, the Commissioner is instructing that insurers should be guided by the statement in the prior Bulletin regarding the information to be included in the notice on individual fixed deferred and immediate annuity contracts sold directly to consumers. Once the rules have been proposed, the rules will contain standards with respect to the contents of such notice consistent with the statements set forth in Bulletin No. 09-06. Pending adoption of these rules, producers and insurers may utilize suitability notices that they currently provide and supplemental pages containing information required by the Act which is not included in the notice. Please note that the law requires that an insurer or producer have "reasonable grounds" for believing that an annuity is suitable for the

consumer and provides that reasonable grounds “shall be based upon all relevant information and circumstances of the consumer actually obtained or known, and recorded, during the time of any negotiation or the offer of sale on the annuity.”

## **B. Acknowledgement of Receipt of Suitability Notice**

The Act requires consumers to acknowledge receipt of the notice that the sale and suitability of the annuities is regulated by the Department and that they have information on how to contact the Department. The signed acknowledgement may be a supplement to the suitability form, both of which should be retained by the insurance producer, non-licensed society agent, representative or member who is selling the annuity product to the consumer. The responsibility for who retains copies of the suitability form and acknowledgment of the consumer may depend upon the marketing channels used and should be a part of the written procedures concerning the negotiation and sale of annuities that are contained in the system of supervision required pursuant to N.J.S.A. 17B:25-38.

## **C. Variable Products**

Please note that variable annuities subject to N.J.S.A. 17B:28-1, et seq. are not subject to the requirements of the Act.

## **D. Immediate Annuity Disclosure Statement**

An immediate annuity disclosure statement should follow the format of the sample fixed annuity disclosure for use in New Jersey as shown in Example 1B of Attachment A to Bulletin

No. 09-06. The immediate annuity disclosure statement should be revised as appropriate to reflect provisions for an immediate annuity. The disclosure statement similar to that for fixed annuities should include, but not be limited to, the requirements detailed at N.J.S.A. 17B:25-37.4.c(1) and (2).

## **E. Expedited Review of Policy Forms**

The Department will provide an expedited review of new or revised form filings as mentioned in Bulletin No. 09-06. Also, to assist in an expedited review, if the free-look provision, buyer’s guide and disclosure statement are not being submitted at the same time, the filing submission should indicate whether they have been previously submitted or approved by the Department and should provide the submission numbers and filing dates. All filings submitted on or after April 1, 2009 must be accompanied by or include a buyer’s guide and disclosure statement that contain the required elements specified in the Act and Bulletin No. 09-06.

Questions regarding the buyer’s guide, disclosure statement or requirements of the Act should be addressed to Reginald Young, Chief, Life Bureau, or can be sent by e-mail to [Reginald.young@dobi.state.nj.us](mailto:Reginald.young@dobi.state.nj.us). Suitability questions should be directed to AnneMarie Narcini, Manager, Consumer Protection Services, at 609-292-5316, ext. 50180 or by e-mail at [Annemarie.narcini@dobi.state.nj.us](mailto:Annemarie.narcini@dobi.state.nj.us). ■

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■ Cynthia J. Borrelli, Esq.

# INSURANCE LAW ALERT

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## ARRA Obligations and COBRA

Recently enacted requirements under the American Recovery and Reinvestment Act (“ARRA”), the economic stimulus law, create new subsidy provisions as well as certain notice obligations for group health plan sponsors subject to Federal COBRA regulations. Specifically, ARRA provides for a 65% COBRA premium subsidy for continuation coverage premiums paid by qualified beneficiaries who lose group health plan coverage stemming from a covered employee’s involuntary termination during the time period of September 1, 2008 through December 31, 2009. In addition, for purposes of federal COBRA, ARRA establishes new laws with regard to notice obligations, as well as new eligibility criteria, new procedures for reimbursing and/or crediting premiums, and new administrative periods.

Notably, ARRA provides that group health plan sponsors or their third-party administrators must provide notice of additional rights available to individuals that became eligible for COBRA continuation coverage because of a qualifying event that occurred on or after September 1, 2008. The deadline for compliance with ARRA’s initial notice requirements was April 18, 2009.

The “additional rights” provided under ARRA temporarily reduce the premium for COBRA coverage for eligible individuals. Individuals who are eligible for COBRA coverage because of their own or a family member’s involuntary termination from employment that occurred from September 1, 2008 through December 31,

2009 and who elect COBRA, may be eligible to pay a reduced premium. Eligible individuals pay only 35% of full COBRA premiums under their plans for up to 9 months. The employer (or other responsible entity) may recover the remaining 65% of the premium by taking the subsidy amount as a credit on its quarterly employment tax return. This premium reduction is generally available for continuation coverage under the federal COBRA provisions, as well as for group health insurance coverage under state continuation coverage laws. Thus, if the individual was offered federal COBRA continuation coverage as a result of involuntary termination of employment that occurred at any time from September 1, 2008 through February 16, 2009, and that individual declined to take COBRA at that time, or elected COBRA and later discontinued it, he/she may have another opportunity to elect COBRA coverage and pay a reduced premium.

COBRA contains provisions giving certain former employees, retirees, spouses, former spouses and children the right to temporary continuation of health coverage at group rates. This coverage is available when coverage is lost due to certain specific events. Employers with 20 or more employees are usually required to offer COBRA coverage and to notify the former employee of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and most state and local governments.

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Notably, there are three elements to qualifying for COBRA benefits, as COBRA establishes specific criteria for employers, beneficiaries and qualifying events. For purposes of this memorandum, our focus is on the first element: plan coverage. The ARRA and COBRA provisions apply to all group health plans sponsored by private-sector employers or employee organizations (unions) subject to the COBRA rules under the Employee Retirement Income Security Act of 1974 (ERISA).

Section 54.4980B of the Code of Federal Regulations (“CFR”) provides rules for determining whether health benefits provided by an employer or employee organization constitute a group health plan for purposes of federal COBRA. Section 4980B further requires that these certain group health plans make continuation coverage available to certain individuals.

For purposes of Section 54.4980B, a group health plan is:

...[a] plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members

of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise... [A] group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it of coverage under the plan would not be available at the same costs to an individual but for the individual’s employment-related connection to the employer or employee organization.

For purposes of Section 54.4980B, “health care has the same meaning as medical care ... [t]hus, health care generally includes the diagnosis, cure, mitigation, treatment or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence.”

For purposes of Section 54.4980B, an “employer” refers to, in pertinent part, a person for whom services are performed.

Notably, “small employer plans” are excepted from COBRA. Under Section 54.4980B, a “small-employer plan” is a group health plan maintained by an employer that normally employed fewer than 20 employees during the preceding calendar year. An employer is considered to have normally employed fewer than 20 employees during a particular calendar year, if, and only if, it had fewer than

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# INSURANCE LAW ALERT

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20 employees on at least 50 percent of its typical business days during that year. The following individuals are not counted as employees for purposes of the Section: (1) Self-employed individuals; (2) Independent Contractors (and their employees and independent contractors); and (3) Directors (in the case of a corporation).

As detailed above, the COBRA premium reduction and correlating notice requirements apply to all group health plans sponsored by private-sector employers subject to the COBRA rules under ERISA. The new COBRA subsidy provisions also apply to insurers required to offer continuation coverage under state law similar to the federal COBRA.

If a group health plan fails to comply with the federal regulations, including, but not limited to, the newly enacted ARRA notice requirements, an excise tax is imposed. Moreover, non-tax remedies may be available if the group health plan fails to comply with the parallel requirements in ERISA. The excise tax, generally, is imposed on the employer maintaining the plan. In certain circumstances, however, the excise tax is also imposed on a person involved with the provision of benefits under the plan, such as an insurer providing benefits under the plan or a third party administrator administering claims under the group health plan.

Finally, we provide a short list of action steps in light of the new compliance burdens under ARRA.

- Review and revise COBRA notices for subsidy information and send out the required notices to qualified beneficiaries

retroactive to September 1, 2008 and to future qualified beneficiaries.

- Review your administrative practices concerning communication of coverage status during a COBRA election period.
- Create a COBRA subsidy update team or designated person to stay current on recent and continued IRS and DOL announcements on the subsidy as well as continuing notice obligations.
- Accumulate and store IRS-mandated information to prove entitlement to the credit, such as records of the Social Security numbers of all covered employees, declarations of involuntary termination, documentation of receipt of the employee's 35 percent share of the premium, whether the subsidy was for one individual or two or more, and in the case of insured plans, a copy of an invoice or other supporting statement from the insurance carrier and proof of timely payment of the full premium to the insurance carrier.
- Coordinate with insurers and third party administrators (TPAs) to ensure coordinated systems and information exchange concerning which qualified beneficiaries are assistance eligible and whether they elected and paid for coverage.
- Investigate which employees were involuntarily terminated from September 1, 2008 and which enrolled in COBRA as of February 17, 2009.

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- Coordinate departments (i.e., HR, payroll) to complete the proper tax reporting forms (including Form 941) to capture the payroll tax credit.
- Review existing severance policies to verify who may be assistance eligible and for how much of a credit.

Certain federal agencies have posted general information regarding ARRA and COBRA:

- <http://www.dol.gov/ebsa/cobra.html>
- [http://www.dol.gov/ebsa//faqs/faq\\_compliance\\_cobra.html](http://www.dol.gov/ebsa//faqs/faq_compliance_cobra.html)
- [http://www.irs.gov/newsroom/article\\_o,,id=204505,00.html](http://www.irs.gov/newsroom/article_o,,id=204505,00.html)
- <http://www.dol.gov/ebsa/COBRAmodeNotice.html>

Clients are urged to contact their third-party administrator or benefit plan advisor to ensure compliance with these new laws. For further information on the COBRA premium subsidy, COBRA obligations under ARRA, or information regarding how to claim the credit for the COBRA medical premiums and IRS Form 941, please feel free to contact Cynthia Borrelli, Jed Marcus or Angela Scafuri. ■

- Angela M. Scafuri, Esq.

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