PIMA SUMMER CONFERENCE
Legislative & Regulatory Report
July 2008

This Newsletter is being presented to the PIMA membership by the PIMA Legislative and Regulatory Action Group. We wish to thank all of the members of the L&R committee for their support with particular thanks to attorneys Sarah Richardson Fahrendorf, of AEGON and Chris Petersen, of Morris, Manning and Martin, for their help in putting this newsletter together.

Co-Chairs

Jerry Wickersham	*Christine Carway*
First Consulting Administration	New York Life

FEDERAL SCENE

Medicare Debate

Medicare reform and health care reform more generally show no signs of fading away before the 2008 Presidential Campaign. Having failed to reach a compromise on Medicare Reform—or even an agreement to forestall the scheduled 10.6% physician payment reduction in advance of their Fourth of July Recess—the Senate left the national stage wide open for others to enter the debate. Unlike past occasions where frustrated Senate negotiations ended with a temporary physician payment fix, this time the Department of Health and Human Services stepped in to stop the cut (scheduled for July 1st) and freeze the current pricing system for a brief period.

In the meantime, the American Medical Association (AMA) and America's Health Insurance Plans (AHIP) have launched aggressive ad campaigns to run during the Fourth of July recess. The AMA's advertisements, running in six states, target by name 10 Republican senators who voted against the measure; seven of the senators face re-election this year. The AMA ads lament, "There's no celebrating for the millions of seniors, the disabled and military families who will lose their access to health care. A group of U.S. Senators voted to protect the powerful insurance companies at the expense of Medicare patients' access to doctors." Similarly, AHIP's ads state that a reduction of payments to Medicare Advantage plans to offset the reduction in physicians' fees will limit access and benefits for beneficiaries.

Just before the scheduled recess, the Senate failed to reach the 60-vote threshold needed to approve a cloture motion for H.R. 6331, the "Medicare Improvements for Patients and Providers Act of 2008," which the House passed earlier the same week. When the cloture motion failed, the bill was withdrawn from the Senate floor. Senate Majority Leader Reid (D-NV) plans to bring up the measure again after the recess.

Medicare Reform n**egotiations in the Senate are best understood by comparing two of the original bills at issue: (1) the "Medicare Improvements for Patients an Providers Act of 2008" (S. 3101), offered by Senator Max Baucus; and (2) the "Preserving Access to Medicare Act of 2008" (S.3118), offered by Ranking Member Charles Grassley.**
The White House threatened a veto of the Baucus bill as well as the more recent Senate bill modeled on H.R. 6331. Senator Grassley claims his bill would not be rejected by the Bush Administration. Senate negotiations must also consider the support of House leaders and the

passage of H.R. 6331 as well as the passage (last year) of the CHAMP Act. While the two Senators agree on many elements in the reform legislation, they disagree on how to pay for it. Baucus' plan has a price tag of $18.2 billion over five years, while the proposal put forth by Sen. Grassley would cost $14.9 billion. Neither the Baucus nor Grassley drafts specify how the bills would be paid for. Both sides want to reduce funding for Medicare Advantage plans, but an initial Republican offer to Democrats May 21st relied on reducing plans' indirect medical education funding and making marketing changes, while Democrats want to go further and slice funding for private fee-for-service plans.

Highlights: The Medicare Improvements for Patients and Providers Act of 2008" (S.3101)

Here is a listing of some of the key positions in Sen. Baucus' bill:

- Sets co-payments from mental health services to match other outpatient medical care.
- Ends the sale of Medigap plans that are redundant as a result of the drug benefit, and modernizes Medigap benefits to better meet seniors' needs.
- Eliminates penalties for late enrollment in the drug benefit by low-income seniors.
- Blocks a cut in physician payments for Medicare services, and increases payments by 1.1% in 2009.
- Eliminates the "double-payment" made to Medicare Advantage plans based on local costs for care at teaching hospitals, as teaching hospitals already received extra payment directly for their sophisticated care.
- Removes almost $1.79 billon dollars from the PPO Regional Stabilization Fund in 2012.
- Prohibits certain sales activities of Medicare Advantage Plans and Part D drug plans, including door-to-door sales, cold calling, free meals and cross-selling of nonhealth-related products, effective for the 2010 year. Also it requires the Secretary to limit co-branding, gifts and commissions. Requires a plan to abide by the state appointment laws affecting agents and brokers.
- Directs the HHS Secretary to implement the revised Medigap benefit standards as approved by the NAIC on March 11, 2007. As such new standards would be effective June 1, 2010.
- Requires prescription drug plans to pay pharmacies within 14 days for clean claims submitted electronically, and 30 days for clean claims submitted otherwise and imposes a monetary penalty on prescription drug plans that fail to pay on time.
- Requires Medicare Part D Prescription Drug Plans to update the drug pricing standards used for pharmacy reimbursement on at least a weekly basis, with an initial update on January 1 each year.
- Certifies the HHS Secretary's current guidance on coverage of the "Protected Classes" of drugs under Part D.

Highlights: Preserving Access to Medicare Act of 2008 (S. 3118)

Here are a few of the key positions in Senator Grassley's bill.

- Increase doctors' pay by 0.5% through the last six months of 2008 and by 1.1% for 2009.
- Increase physician incentive payments under the Physician Assistance and Quality Initiative (PAQI) fund.
- Provide financial incentives for the use of e-prescribing.
- Promote value based purchasing and the use of electronic health records.
- Maintain and improve access to care in rural areas.
- Address Medicare Advantage marketing practices to curb abusive activities.
- Require Medicare Advantage plans to report on quality.

Highlights from the Senate Finance Committee's Health Reform Summit

On June 16, 2008, Senate Finance Committee Chairman Max Baucus (D-MT) and Ranking Member Chuck Grassley (R-IA) co-hosted a bipartisan summit at the Library of Congress to discuss options for health care reform in 2009. "*Prepare for Launch: Health Reform Summit 2008*" is part of the Finance Committee's year-long series of hearings, roundtables, and events to prepare for congressional action on health reform. The summit featured keynote speakers Federal Reserve Chairman Ben Bernanke, addressing health care and American economic competitiveness, and genomic research pioneer Dr. J. Craig Venter, speaking on research advances and signposts for reform. The summit also featured multiple member-led sessions on topics including: state-based reform, delivery system reform (transparency and value-based purchasing), international health systems, the role of public programs, and curbing health care spending.

Chairman Bernanke's Assessment

Bernanke noted that health care spending comprises more than 15% of the U.S. economy and is the "single largest component of personal consumption, larger than spending on either housing or food." He noted that if the pace continues, health spending would exceed 22% of gross domestic product by 2020 and represent 50% of all federal spending by 2050. "From the economist's perspective, the question of whether we are spending too much on health care cannot ultimately be answered by looking at total expenditures relative to GDP or the federal budget," rather, "the question, whatever we spend, is whether we are getting our money's worth." Bernanke mused, "In devising policies to reform our health care system, we must take care to maintain the vitality and spirit of innovation that has been its hallmark."

Senator Baucus' Independent Board Concept

Finance Committee Chair Max Baucus (D-Mont.) asked Bernanke about the prospect of developing an independent board of health experts, similar to the Federal Reserve, to address technical aspects of the health care system, such as the proper reimbursement rate for a certain procedure. Bernanke responded that he was "skeptical" whether politics could be kept out of the reform processes addressed by such a board. He said such an entity could serve one of three roles: (1) a simple board that would make recommendations; (2) a commission that would generate suggestions to be voted on by Congress, similar to the board used in deciding whether to close military bases; or (3) a technical board that Congress could order to make complex determinations related to health coverage.

Postscript: Sen. Baucus, CBO Advance Board Concept

After the hearing, Baucus remarked, "we need some cohesion, some discipline, some organized way to deal with most, if not all, the component parts of health care." He added that an appropriate approach would reduce "the direct interest group influence on Congress on matters that we in some respects are not competent to address, like minute Medicare reimbursement questions." Congressional Budget Office (CBO) Director Peter Orszag offered that Sen. Baucus could ask CBO and the Government Accountability Office (GAO) to study the possibility of such a board. Orszag, who did not necessarily endorse the creation of an independent board, said Congress could "delegate some degree of authority to create a professional and insulated body that can make decisions" on important health policy matters such as those related to coverage and reimbursement. Orszag also said the commission could resemble the Medicare Payment

Advisory Commission (MedPAC) but "have the power to go beyond just recommending" to "actually implementing the policy." In addition, a federal health board could play a role in reducing regional variations in health care services, which could save billions of federal dollars without impacting quality.

Health Care Reform

"Why the Health Care Marketplace is Broken"
The Senate Finance Committee held a related hearing on June 6, where Committee Chairman Sen. Max Baucus voiced concern about private insurers' difficulty in providing affordable options, employer cutbacks in benefits and cost shifting to employees, and the denial or rescission of coverage to individuals with medical histories. Sen. Charles Grassley expressed concern about costs and presented findings that showed that self-pay patients were charged two and a half times more for hospital care than insured patients. Ronald Williams, Chairman and CEO of Aetna, cited the following as blocking universal coverage: a) high and rising health care costs, b) state regulations that preclude affordable coverage, c) the individual marketplace, and d) access problems associated with individuals who are eligible for but not enrolled in public programs. It is expected that these issues will continue on the 2009 agenda.

Preexisting Condition Exclusion

Sens. F. Lautenberg and S. Brown introduced S. 3115, the "Children's Health Protection Act". This bill would prohibit group and individual health plans from imposing any preexisting condition exclusion for individuals under the age of 19. A companion bill, H.R. 2842 was introduced in the House. H.R. 2833 and S. 2236 proposed changes to the HIPAA preexisting condition rules. They would reduce from six months to 30 days the look back period to determine if the condition was preexisting and they would reduce from 12 months to three months the timeframe during which the condition can be excluded.

HSA Changes

On April 15, the House approved a provision proposing new requirements for Health Savings Accounts (HSAs) as part of H.R. 5719 the "Taxpayer Assistance and Simplification Act of 2008". It includes a provision that would require HSA account-holders to follow substantiation requirements similar to those that currently apply to Flexible Spending Accounts beginning in 2011. Health Savings Account (HSAs) has seen increased enrollment levels. A new census found that more than 6.1 million Americans are covered by HSA eligible plans, a 35% increase since last year. The survey reflected that 30% of individuals covered by HSA plans were in small group markets and that 45% were in the large group market, with the remaining 25% being in the individual market.

Lifetime Limits

Sen. B. Dorgan introduced S. 2706 which would prohibit group health plans from imposing an aggregate dollar lifetime limit of less than $5 million during the first two years after the bill's enactment and no less than $10 million during the third and fourth years with future year limits being adjusted by the consumer price index.

FTC Focus: Online Behavioral Advertising

In December 2007, the FTC staff released a set of proposed principles to guide the development of self-regulation in consumer privacy concerns associated with online behavioral advertising. The comment period was extended through April 2008. Online behavioral advertising is the

tracking of consumers' activities online – including: the searches the consumer has conducted; the web pages visited; and the content viewed – in order to deliver advertising targeted to the individual consumer's interests.

The four proposed principles include:

1. Transparency & Consumer Control

   Every website should provide a clear, concise, consumer-friendly and prominent statement that:
   - Data about consumers' activities online is being collected for providing advertising about products/services tailored to consumers' interests, and
   - Consumers can choose whether or not to have their information collected for such purpose. The website should also provide a clear method to exercise this option.

2. Reasonable Security & Limited Data Retention For Consumer Data

   Provide reasonable security consistent with data security laws & FTC's data security enforcement actions. Companies should retain data only as long as it is necessary to fulfill a legitimate business or law enforcement need. FTC staff commends recent efforts by some industry members to reduce the time period for which they are retaining data.

3. Affirmative Express Consent For Material Changes To Existing Privacy Promises

   Before a company can use data in a manner materially different from statements the company made when it collected the data, it should obtain consent. This would apply in a corporate merger situation, to the extent it materially changes the way data is collected, used and/or shared.

4. Affirmative Express Consent To Using Sensitive Data For Behavioral Advertising

   Companies should only collect sensitive data if they obtain affirmative express consent from the consumer to receive advertising.

NAIC ISSUES

Associations/Producer Licensing

At previous meeting there had been some discussion among regulators as to whether certain types of association marketing efforts would require an association to receive a producer license. That issue has appeared to be pushed to the backburner. There does not appear to be a champion for the issue and without a champion it is unlikely that this issue will move forward.

Policy Rescissions/Exclusionary Riders

The NAIC's Regulatory Framework Taskforce adopted a new charge to look at policy rescissions and exclusionary group riders. Initially the charge was limited to individual policies, but after a regulator asked whether the charge should apply to association coverage the Taskforce voted to expand the charge. The charge now all applies to policy rescissions under all group policies and exclusionary riders for all individually underwritten policies.

Extraterritoriality/Jurisdictional Issues

The NAIC is developing a white paper that is examining extraterritoriality and jurisdictional issues. The draft outline that was released indicates that the major focus of the paper will be employer-sponsored managed care. When asked whether the paper would examine association issues and other group products the regulator chairing the work group responded, "no, association coverage was addressed in the amendments to the group model act." Although associations will not be specifically addressed by the white paper, there will probably be spill over into the products that offered through associations.

External Review

After much debate and a close vote, the NAIC adopted revisions to its External Review Model Act. The revisions were designed to adopt a uniform version of external review. Debate was largely centered on whether a vote for the model committed a commissioner to affirmatively attempt to have the model adopted in his or her home state or whether, under new NAIC rules, a vote merely indicated a commissioner's support for the underlying model and the concept of uniformity. HIPAA's "excepted benefits" products such as Medicare supplement, hospital indemnity, specified disease, dental, disability income and long-term care insurance are exempted from the model Act. However, the NAIC is considering adopting an external review model for long-term care insurance.

Return of Premium

The NAIC Life and Health Actuarial Task Force (LHATF) has been charged to develop guidelines for determining minimum cash values for Return of premium Products.

STATE ISSUES

California: 10133.8. Commissioner's Authority over Translated Material

(a) The commissioner shall, on or before January 1, 2006, promulgate regulations applicable to all individual and group policies of health insurance establishing standards and requirements to provide insureds with appropriate access to translated materials and language assistance in obtaining covered benefits. A health insurer that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its population for purposes of subparagraph (A) of paragraph (3) of subdivision (b). An insurer that chooses to separate its Healthy Families Program enrollment from the remainder of its population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (3) of subdivision (b) is applicable and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (3) of subdivision (b).

(b) The regulations described in subdivision (a) shall include the following:

  (1) A requirement to conduct an assessment of the needs of the insured group, pursuant to this subdivision.

  (2) Requirements for surveying the language preferences and assessment of linguistic needs of insureds within one year of the effective date of the regulations that permit health insurers to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and

language translation requirements every three years. However, the regulations may provide that the surveys and assessments by insurers of supplemental insurance products may be conducted less frequently than three years if the commissioner determines that the results are unlikely to affect the translation requirements.

(3) Requirements for the translation of vital documents that include the following:

   (A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

      i. A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 0.75 percent or 15,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

      ii. A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 1 percent or 6,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

      iii. A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

   (B) Specification of vital documents produced by the insurer that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

      i. Applications.

      ii. Consent forms.

      iii. Letters containing important information regarding eligibility or participation criteria.

      iv. Notices pertaining to the denial, reduction, modification, or termination of services and benefits, the right to file a complaint or appeal.

      v. Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to insureds.

      vi. Translated documents shall not include an insurer's explanation of benefits or similar claim processing information that is sent to insureds unless the document requires a response by the insured.

   (C) For those documents described in subparagraph (B) that are not standardized but contain insured specific information, health insurers shall not be required to translate the documents into the threshold languages identified by the needs

assessment pursuant to paragraph (2) of subdivision (b) but rather shall include with the document a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment pursuant to paragraph (2) of subdivision (b).

i. Upon request, the insured shall receive a written translation of those documents. The health insurer shall have up to, but not to exceed, 21 days to comply with the insured's request for a written translation. If an enrollee requests a translated document, all timeframes and deadlines requirements related to the documents that apply to the health insurer and insureds under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health insurer's issuance of the translated document.

ii. For appeals that require expedited review and response in accordance with the statutes and regulations of this chapter, the health insurer may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health insurers advise limited-English-proficient insureds of the availability of interpreter services.

(4) Standards to ensure the quality and accuracy of the written translation and that a translated document meets the same standards required for the English version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(5) Requirements for individual access to interpretation services.

(6) Standards to ensure the quality and timeliness of oral interpretation services provided by health insurers.

(A) In developing the regulations, standards, and requirements described in this section, the commissioner shall consider the following:

(1) Publications and standards issued by federal agencies, including the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy Guidance 65 (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, including the Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health insurers that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health insurers.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically

Competent Physicians and Dentists required pursuant to Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health insurers that contract for alternative rates of payment with providers, including existing practices.

(7) Information gathered from complaints to the commissioner and consumer assistance help lines regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in networks and method of service delivery. The commissioner shall allow for health insurer flexibility in determining compliance with the standards for oral and written interpretation services.

   A. In designing the regulations, the commissioner shall consider all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. The commissioner shall seek public input from a wide range of interested parties.

   B. Services, verbal communications, and written materials provided by or developed by the health insurers that contract for alternative rates of payment with providers, shall comply with the standards developed under this section.

   C. Beginning on January 1, 2008, the department shall report biennially to the Legislature regarding health insurer compliance with the standards established by this section, including results of compliance audits made in conjunction with other audits and reviews.

The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The commissioner shall work to ensure that the biennial reports required by this section, and the data collected for the reports, do not require duplicative or conflicting data collection with other reports that may be required by government-sponsored programs. The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

Nothing in this section shall prohibit government purchasers from including in their contracts additional translation or interpretation requirements, to meet the linguistic and cultural needs, beyond those set forth pursuant to this section.

<u>New York:</u> Suitability and Replacement Standards for Life & Annuity Transactions

The NYS Commission to Modernize the Regulation of Financial Services together with the New York State Insurance Dept. released a draft regulation that would establish suitability and replacement standards for life and annuity transactions. The draft goes well beyond the NAIC Suitability in Annuity Transactions Model and the NAIC Replacement Model. It would require the gathering a great of personal information from the applicant and prior to issuing any coverage the insurer must review each transaction to determine suitability. There is no provision for delegation of this suitability review responsibility to third parties and there is no expressed exemption for direct response solicitations. The Department has indicated that they would repeal the existing Reg. 60 on replacements and substitute a suitability regulation.

<u>Oregon:</u> Exemption for Out-of-State Health Insurance Plans Removed

Legislation was passed (H.B. 3321) that has removed the exemption for out-of-state health insurance plans and mandates that coverage under a master group health policy that is delivered or issued for delivery outside of Oregon to an association or trust may only be offered if the Department determines that it meets the standards established by ORS743.522 (10(b)or(c)or (2)).

Military Sales Practices Legislation

The Military Personnel Financial Services Protection Act was enacted in September 2006 to protect members of the United States Armed Forces from unscrupulous practices regarding the sale of insurance, financial, and investment products on and off military installations. The Act required states to enact rules that meet the NAIC sales practice standards by September 29, 2007.

<u>NAIC Model Regulation - Military Sales Practices</u>

The purpose of the model regulation is to set forth standards to protect active duty service members from dishonest and predatory insurance sales practices by declaring certain practices as false, misleading, deceptive or unfair. The model does not create a private right of action. The model applies to the solicitation or sale of life insurance to an active duty service member. Solicitation does not mean general advertisement, direct mail, Internet marketing or telemarketing. Under the model, life insurance may include AD, AD&D and disability income.

Practices Declared False, Misleading, Deceptive or Unfair

(1) Practices on a Military Installation

- Soliciting door-to-door or without an appointment.
- Soliciting in a group where attendance is not voluntary.
- Knowingly making appointments during normally scheduled duty hours.
- Soliciting/appointments in areas where prohibited.
- Soliciting without obtaining permission from Commander.
- Posting unauthorized bulletins, notices or advertisements.
- Failing to present form - Personal Commercial Solicitation Evaluation.
- Accepting an application on the life of an enlisted member without confirming whether the applicant has fulfilled requirements for the sale of life insurance established by the U.S. Department of Defense.
- Using U.S. Department of Defense personnel to solicit service members.
- Using a producer to participate in a sponsored education or orientation program.

(2) Practices Regardless of Location

- Assisting in the submission of any form used by the Armed Forces to direct pay to a third party for the purchase of life insurance. Does not prohibit providing information necessary to complete any form.
- Knowingly receiving funds for payment from a depository institution that has no formal banking relationship with service member.
- Using a method whereby funds received for the payment of premiums are identified on the Leave and Earnings Statement as “Savings” or “Checking”, where there is no formal banking relationship.

- Entering into any agreement with a depository institution for the purpose of receiving funds from a member whereby the depository institution agrees to accept direct deposits where no formal banking relationship exists.
- Using U.S. Department of Defense personnel in the solicitation of service members who are junior in rank or grade, or of the family members of such personnel.
- Offering or giving anything of value to U.S. Department of Defense personnel to procure their assistance in the sale to service members.
- Offering or giving anything of value to a service member for attendance to any event where life insurance is solicited.
- Advising a service member to change his/her income tax withholding or state of residence for the purpose of increasing disposable income to purchase life insurance
- Making any representation that has the capacity to mislead a service member into believing that the insurer, producer or product is endorsed, sponsored, sanctioned or recommended by any state or federal agency or entity.
- Soliciting through the use of, or in conjunction with, any third party organization that promotes the welfare of assistance of service members in a manner that has the capacity to mislead a service member into believing that the insurer, producer or the product is endorsed, sponsored, sanctioned or recommended by any state or federal agency or entity.
- Using or describing the credited interest rate of a life policy in a manner that implies that the credited interest rate is a net return on premium paid.
- Misrepresenting the mortality costs of a life product, stating or implying that the product "costs nothing" or is "free".
- Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.
- Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI by private insurers, which is false, misleading or deceptive.
- Suggesting, recommending or encouraging a service member to cancel or terminate his/her SGLI policy or issuing a life policy which replaces an existing SGLI policy unless the replacement shall take effect after the separation from the Armed Forces.

(3) Disclosure Practices (Regardless of Location)

- Using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer for the purpose of soliciting the purchase of life insurance.
- Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for a face-to-face meeting with a prospective purchaser.
- Failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.
- Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the "Military Personnel Financial Services Protection Act".
- When the sale is conducted face-to-face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

- An explanation of any free look period with instructions on how to cancel if a policy is issued; and
- Either a copy of the application or a written disclosure. A basic illustration that meets the state's requirements of the illustration or disclosure regulation shall be deemed sufficient to meet this requirement for a written disclosure.

(4) Practices Regarding Sale of Certain Life Products (Regardless of Location)

- Recommending the purchase of any life insurance product, which includes a side fund to a service member unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.
- Offering for sale or selling a life insurance product which includes a side fund to a service member who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.
    - "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.
    - "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income
      Tax Forgiveness, and Social Security Survivor Benefits.
- Offering for sale or selling any life insurance contract which includes a side fund:
    - Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;
    - Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year 1-10 and for every 5th policy year thereafter ending at age 100, policy maturity or final expiration; and which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.
- Offering for sale or selling any life insurance contract which, after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard non-forfeiture law for life insurance.
- Selling any life insurance product that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service except for accidental death coverage, e.g., double indemnity, which may be excluded.

Status – A chart is provided.