

## Assembly Bill No. 999

### CHAPTER 627

An act to amend Sections 10234.6, 10234.93, 10236.1, 10236.13, and 10236.14 of, and to add Section 10236.2 to, the Insurance Code, relating to long-term care insurance.

[Approved by Governor September 27, 2012. Filed with Secretary of State September 27, 2012.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 999, Yamada. Long-term care insurance.

Existing law provides for the regulation of insurers by the Department of Insurance, including insurers issuing policies of long-term care insurance. Existing law regulates the marketing or solicitation of long-term care insurance policies and, in that regard, requires specified disclosures to prospective applicants or enrollees. Existing law requires the Insurance Commissioner to annually prepare a consumer rate guide for long-term care insurance and to include specified information.

This bill would require an insurer of long-term care insurance to clearly post on its Internet Web site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered by the insurer is available upon request and to provide that form within 15 calendar days upon request.

This bill would require the annual consumer rate guide to include a specimen outline of coverage for each product currently marketed by each insurer listed in the rate guide.

Existing law requires the premium rate schedules for all individual and group long-term care insurance policies issued in this state to be filed with, and receive the prior approval of, the Insurance Commissioner before the policy may be offered, sold, issued, or delivered to a resident of this state. Existing law requires an insurer of long-term care insurance to submit to the Insurance Commissioner for approval all proposed premium rate schedule increases and to include specified information with the rate application, including, but not limited to, certification by an actuary as to specified matters. Approval of all premium rate schedule increases is subject to specified criteria.

This bill would provide that if the premiums in any rate revision filing calculated pursuant to those criteria produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for the policy form in the initial filing or for requested premium rates in any filing made after January 1, 2013, the insurer would be required to reduce the premiums in that filing such that the current lifetime expected loss ratio is equal to or greater than the highest filed loss ratio, as specified. The bill would set forth

criteria for calculating the margin in the determination of a lifetime expected loss ratio.

Existing law prohibits an approval for an increase in the premium schedule from being granted unless the actuary performing the review for the Insurance Commissioner certifies that if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated.

This bill would eliminate those provisions and, instead, authorize an insurer to request a premium rate schedule increase that is lower than the rate increase necessary to provide the required certification or a series of premium rate schedule increases with a present value of not more than the rate increase necessary to provide that certification. The bill would authorize the Insurance Commissioner to approve this request if, in his or her opinion, accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders, and other conditions are satisfied, as specified.

For long-term care insurance policies, the bill would also prohibit an insurer from justifying a rate increase prior to approval by the Insurance Commissioner based upon asset investment yield rate changes, except as specified, and would require all of the experience on all similar long-term care policy forms issued by an insurer and its affiliates and retained within the affiliated group to be pooled together and used as the basis for determining whether an increase is reasonable or shall be approved under specified provisions. The bill would require similar long-term care policy forms to be classified into benefit classifications of nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits.

*The people of the State of California do enact as follows:*

SECTION 1. Section 10234.6 of the Insurance Code is amended to read:

10234.6. (a) The commissioner shall, by June 1 of each year, jointly design the format and content of a consumer rate guide for long-term care insurance with a working group that includes representatives of the Health Insurance Counseling and Advocacy Program, the insurance industry, and insurance agents. The commissioner shall annually prepare the consumer rate guide for long-term care insurance that shall include, but not be limited to, the following information:

(1) A comparison of the different types of long-term care insurance and coverages available to California consumers and a specimen outline of coverage for each product currently marketed by each insurer listed in the rate guide.

(2) A premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in California.

(b) The consumer rate guide to be prepared by the commissioner shall consist of two parts: a history of the rates for all policies issued in California for the current year and for four preceding years, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California.

(1) For the rate history portion of the rate guide required by this section, the department shall collect, and each insurer shall provide to the department, all of the following information for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in California for the current year and for four preceding years:

- (A) Company name.
- (B) Policy type.
- (C) Policy form identification.
- (D) Dates sold.
- (E) Date acquired (if applicable).
- (F) Premium rate increases requested.
- (G) Premium rate increases approved.
- (H) Dates of premium rate increase approvals.
- (I) Any other information requested by the department.

(2) For the policy comparison portion of the rate guide required by this section, the department shall collect, and each insurer shall provide to the department, the information needed to complete the following form, along with any other information requested by the department, for each long-term care policy currently issued for delivery in California, including all policies, whether issued by the insurer or purchased or acquired from another insurer:

<b>INSURANCE COMPANY NAME</b>	<b>Policy Form Number</b>		
[List policy name for this form number, whether nursing home and residential care only, home care only, comprehensive, individual or group, partnership, tax or nontax qualified, all issue ages available, reimbursement or per diem.]			
<b>Maximum Policy Benefit</b> [List all maximum benefit amounts in years offered and dollars.]	30** day elimination period 3 year maximum policy benefit / \$109,000 * Other assumptions		
<b>Nursing Home Daily Benefit Amount</b> [List range in which daily benefit is offered from minimum to maximum.]	Issue Age	\$100 Daily Benefit Amount for Nursing Home & Home Care	\$100 Daily Benefit Amount for Nursing Home & Home Care (with 5% compound Inflation Protection)
<b>Residential Care Daily Benefit Amount *</b> [List all percentage amounts for which residential care benefits are offered as a percentage of the nursing home daily benefit.]	50		
	55		
	60		
	65		
	70		
	75		
<b>Home Care Benefit Amount</b> [List all percentage amounts for which home care benefits are offered as a percentage of the daily nursing home benefit. Specify whether paid as daily, weekly, or monthly.]	80		
	Other ages may be available.		
<b>Elimination Period</b> [List all days and/or amounts in which elimination periods are offered. Specify how policy counts home care service days towards elimination period.]	30** day elimination period Lifetime Benefit / Unlimited * Other assumptions		
	Issue Age	\$100 Daily Benefit Amount for Nursing Home & Home Care	\$100 Daily Benefit Amount for Nursing Home & Home Care (with 5% compound Inflation Protection)
<b>Inflation Protection</b> [List all options offered for inflation protection adjustment.]	50		
	55		
	60		
	65		
	70		
	75		
<b>Waiver of Premium</b> [List all options for comprehensive, nursing home only and home care only. Qualification rules.]	80		
	Other ages may be available.		

\*The residential care benefit is \_\_\_\_% of the daily nursing home benefit. If this is a comprehensive policy, the home care benefit is \_\_\_\_% of the daily nursing home benefit. If this is a home care only policy, the daily benefit is \$ \_\_\_\_\_. [List the minimum amount available on the company's policy forms as a percentage of the daily nursing home benefit.]

Please refer to Section # for information on premium increases, if any, since 1990 for this company

[\*\* Carrier may use 20-day elimination period if a 30-day elimination period is not offered.]

If an insurer does not offer a policy for sale that fits the criteria set forth in the sample premium portion of the policy comparison section of the rate guide, the department shall include in that section of the form for that policy a statement explaining that a policy fitting that criteria is not offered by the insurer and that the consumer may seek, from an agent, sample premium information for the insurer's policy that most closely resembles the policy in the sample.

The department shall use the format set forth in this section for the policy comparison portion of the rate guide, unless the working group convened pursuant to subdivision (a) designs an alternative format and agrees that it should be used instead.

In compiling the policy comparison portion of the rate guide, the department shall separate the group policies from the individual policies available for sale so that group policies for all insurers appear together in the guide and individual policies for all insurers appear together in the guide.

The policy comparison portion of the rate guide shall contain a cross-reference for each policy form listed indicating the page in the rate guide where rate information on the policy form can be found.

(c) The department shall publish, on the department's Internet Web site, a premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in each state. Each insurer shall provide to the department all of the information listed in paragraph (1) of subdivision (b) for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in the United States for the current year and for the nine preceding years.

(d) Insurers shall provide the information required pursuant to subdivisions (b) and (c) no later than July 31 of each year, commencing in 2000.

(e) The consumer rate guide shall be published no later than December 1 of each year commencing in 2000, and shall be distributed using all of the following methods:

(1) Through Health Insurance Counseling and Advocacy Program (HICAP) offices.

(2) By telephone using the department's consumer toll-free telephone number.

(3) On the department's Internet Web site.

(4) A notice in the Long-Term Care Insurance Personal Worksheet required by Section 10234.95.

(f) Notwithstanding any other provision of law, the data submitted by insurers to the department pursuant to this section are public records, and shall be open to inspection by members of the public pursuant to the procedures of the California Public Records Act. However, a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, is not subject to this subdivision.

SEC. 2. Section 10234.93 of the Insurance Code is amended to read:

10234.93. (a) Every insurer of long-term care in California shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.

(4) Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for resident licensees, shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section:

(A) For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter eight hours of training prior to each license renewal.

(B) For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal.

(C) For nonresident licensees that are not otherwise subject to the continuing education requirements set forth in Section 1749.3, the evidence of training required by this section shall be filed with and approved by the commissioner as provided in subdivision (g) of Section 1749.4.

Licensees shall complete the initial training requirements of this section prior to being authorized to solicit individual consumers for the sale of long-term care insurance.

The training required by this section shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. On or before July 1, 1998, the following additional training topics shall be required: differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, and NAIC consumer suitability standards and guidelines.

(5) Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(6) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

(7) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision.

(8) Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

(9) Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.

(10) Clearly post on its Internet Web site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered in this state is available to a prospective applicant upon request. The individual specimen policy form or group master policy and certificate form shall be provided to a requesting party within 15 calendar days or receipt of a request.

(b) In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

SEC. 3. Section 10236.1 of the Insurance Code is amended to read:

10236.1. (a) Benefits under individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11 shall be deemed reasonable in relation to premiums if the expected loss ratio is at least 60 percent, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(b) (1) For individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11, and for which rate revisions are filed on or after January 1, 2010, benefits shall be deemed reasonable in relation to the premium if the premium rate schedules have a lifetime expected loss ratio of at least 60 percent of the premium scale in effect on December 31, 2009, plus 70 percent of premium increases filed on or after January 1, 2010, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(2) However, if the premiums in any rate revision filing calculated in the manner provided in paragraph (1) produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, a margin may reflect changes in the manner in which risks are shared between the insurer and a block of policies due to changes in this law effective January 1, 2013, and that margin shall not be increased unless the manner in which risks are shared between the insurer and the block of policies is changed further by law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies in force at the time of the first filing after January 1, 2013, and not any prior assumed distribution.

(c) In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(1) Statistical credibility of incurred claims experience and earned premiums.

(2) The period for which rates are computed to provide coverage.

(3) Experienced and projected trends.

(4) Concentration of experience within early policy duration.

(5) Expected claim fluctuation.

(6) Experience refunds, adjustments, or dividends.

(7) Renewability features.

(8) All appropriate expense factors.

(9) The discount rate used in the calculation of lifetime expected loss ratios.

(10) Experimental nature of the coverage.

(11) Policy reserves.

(12) Mix of business by risk classification.

(13) Product features, such as long elimination periods, high deductibles, and high maximum limits.

(d) Asset investment yield rate changes may not be used to justify a rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(e) The experience on all similar long-term care policy forms issued in this state by an insurer and its affiliates and retained within the affiliated group shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivisions (a) and (b). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing



facility and residential care facility only, home care only, or comprehensive long-term care benefits.

(f) Notwithstanding any other provision of this section, for rate revisions filed on or after January 1, 2010, the commissioner may approve an application for a rate revision based on less than a 70 percent loss ratio, but not less than a 60 percent loss ratio, for the portion attributable to the rate increase if an insurer can demonstrate that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(g) This section applies only to long-term care insurance policies issued before the approval of rate schedules under Section 10236.11.

SEC. 4. Section 10236.2 is added to the Insurance Code, to read:

10236.2. Except where the provisions of a group contract provide otherwise, the provisions of subdivisions (d) and (e) of Section 10236.1 shall apply to all group long-term care insurance policies issued before the approval of premium rate schedules under Section 10236.11.

SEC. 5. Section 10236.13 of the Insurance Code is amended to read:

10236.13. No insurer may increase the premium for an individual or group long-term care insurance policy or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner.

The insurer shall submit to the commissioner for approval all proposed premium rate schedule increases, including at least all of the following information:

(a) Certification by an actuary, who is a member of the American Academy of Actuaries and who meets the qualification standards of that organization, that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated.

(2) The premium rate filing is in compliance with the provisions of this section.

(b) An actuarial memorandum justifying the rate schedule change request that includes all of the following:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date shall be provided separately.

(B) The projections shall include the development of the lifetime loss ratio.

(C) For policies issued with premium rate schedules approved under Section 10236.11, the projections shall demonstrate compliance with subdivision (a) of Section 10236.14. For all other policies, the projections shall demonstrate compliance with Section 10236.1.

(D) If the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, then:

(i) The projected experience should be limited to the increases in claims expenses attributable to the changes in law or regulations.

(ii) If the commissioner determines that potential offsets to higher claims costs may exist, the insurer shall be required to use appropriate net projected experience.

(2) Disclosure of how reserves have been incorporated in this rate increase.

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary.

(4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.

(5) A statement that asset investment yield rate changes have not been used to justify the rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(6) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates.

(c) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner.

(d) Sufficient information for approval of the premium rate schedule increase by the commissioner.

(e) (1) The insurer, at its discretion, may request a premium rate schedule increase that is lower than the rate increase necessary to provide the certification required by subdivision (a) or a series of premium rate schedule increases with a present value of not more than the rate increase necessary to provide the certification required by subdivision (a). The commissioner may accept the premium rate schedule increase or series of increases without submission of the certification required by subdivision (a) if all of the following apply:

(A) In the opinion of the commissioner, accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders.

(B) The actuarial memorandum discloses to the commissioner the rate increase necessary to provide the certification required by subdivision (a).

(C) The rate increase filing satisfies all other requirements of this section.

(D) The insurer discloses to policyholders affected by the approved increases the filed increase, the approved premium rate schedule increase

or increases, and the amount and timing of any subsequent rate schedule increases included in the rate increase filing whether those subsequent rate schedule increases are approved or not approved by the commissioner.

(2) The commissioner may approve a lower requested premium rate schedule increase and may approve the initial increase or more than just the initial increase requested pursuant to paragraph (1).

(3) If the amount of increase after all increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner, triggers the contingent benefit upon lapse, the commissioner shall require the administration by an insurer of the contingent benefit upon lapse as a condition of approval of a premium rate schedule increase that is lower than the amount necessary to provide the certification required by paragraph (1) of subdivision (a) or with the initial increase and each subsequent increase in a series of premium rate schedule increases. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(4) For purposes of paragraph (2) of subdivision (a) of Section 10236.14, the loss ratio calculation shall assume future premiums are based on the total filed rate schedule increase or series of increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner.

(5) Premium rate schedule increases requested pursuant to paragraph (1) or approved as described in paragraph (2) shall comply with the provisions of Sections 10234.6 and 10234.95.

(f) The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.

SEC. 6. Section 10236.14 of the Insurance Code is amended to read:

10236.14. Approval of all premium rate schedule increases shall be subject to the following requirements:

(a) (1) Premium rate schedule increases shall demonstrate that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times 58 percent.

(B) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(C) The present value of future projected initial earned premiums times 58 percent.

(D) Eighty-five percent of the present value of future projected premiums not in subparagraph (C) on an earned basis.

(2) However, if the premiums in any rate revision filing calculated in this manner produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the

insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, the margin for moderately adverse experience shall be reflected and shall not be increased unless the manner in which risks are shared between the insurer and block of policies has been changed by this law or any future law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies issued and not any assumed distribution prior to actual sales.

(b) In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, a premium rate schedule increase may be approved if the increase provides that 70 percent of the present value of projected additional premiums shall be returned to policyholders in benefits and the other requirements applicable to other premium rate schedule increases are met.

(c) All present and accumulated values used to determine rate increases should use the maximum valuation interest rate for contract reserves. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(d) No request for a rate increase on any policy form approved under Section 10236.11 shall be approved by the commissioner except as follows: the experience on all similar long-term care policy forms issued in this state by the insurer and its affiliates and retained by the affiliated group that have been approved either prior to approval under, or pursuant to, Section 10236.11 shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivision (a). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits. An insurer is not precluded from filing requests for premium rate schedule increases on all of its policy forms if the combined experiences after pooling all applicable policy forms satisfies the requirements of subdivision (a).

(e) Notwithstanding any other provision of this section, for applications for rate revisions filed on or after January 1, 2013, the commissioner may approve the application if an insurer demonstrates that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(f) The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.