

AMENDED IN SENATE APRIL 5, 2010

**SENATE BILL**

**No. 1163**

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**Introduced by Senator Leno**

February 18, 2010

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An act to amend Sections 1389.25 and 1389.4 of, and to add Sections 1389.26 and 1389.45 to, the Health and Safety Code, and to amend Sections 10113.9 and 10113.95 of, and to add Sections 10113.91 and 10113.96 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1163, as amended, Leno. Health care coverage: denials: premium rates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law requires a health care service plan that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing. Existing law also prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice *at least 30 days prior to the effective date of the change*.

This bill would require a health insurer that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in

writing. With respect to both health insurers and health care service plans issuing individual policies or contracts, the bill would require that the reasons for a denial or a higher than standard rate be stated in clear, easily understandable language. *The bill would require notice of a change to the premium rate of coverage to be provided at least 180 days prior to the effective date of the change.*

The bill would also require a health care service plan or health insurer that offers health care coverage in the large group market to provide a group to which it denies coverage or enrollment or to which it offers coverage at a higher than standard rate, with the specific reason or reasons for that decision in writing in clear, easily understandable language.

Existing law requires a health care service plan and a health insurer to annually file with the Department of Managed Health Care or the Department of Insurance a general description of the criteria, policies, procedures, or guidelines the plan or insurer uses for rating and underwriting decisions related to individual contracts and policies.

This bill would require a plan or insurer to annually disclose to the Department of Managed Health Care or the Department of Insurance the standards, processes, and criteria used by the plan or insurer to deny issuance of a large group contract or policy. The bill would also require a plan or insurer issuing coverage in the individual or large group market to annually disclose to the Department of Managed Health Care or the Department of Insurance the number and proportion of individual or group applicants denied coverage during the preceding year, and the reasons therefor, the number and proportion of enrollees, insureds, or groups that paid a premium rate ~~other~~ *that was higher* than the standard rate, and the reasons therefor, and the standards, processes, and criteria used by the plan or insurer for adjusting premiums applicable to individual or large group contracts or policies based on health status or any other risk factor, as specified. *For large groups, the bill would also require reporting of the number and proportion of those groups that paid a premium rate lower than the standard rate, and the reasons therefor.* The bill would require the departments to disclose this information, and the information obtained from plans and insurers from the annual filing described above, to the public, the Managed Risk Medical Insurance Board, and the relevant policy and budget committees of the Legislature, as specified.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Section 1389.25 of the Health and Safety Code  
2 is amended to read:

3 1389.25. (a) (1) This section shall apply only to a full service  
4 health care service plan offering health coverage in the individual  
5 market in California and shall not apply to a specialized health  
6 care service plan, a health care service plan contract in the  
7 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
8 of Part 3 of Division 9 of the Welfare and Institutions Code), a  
9 health care service plan conversion contract offered pursuant to  
10 Section 1373.6, a health care service plan contract in the Healthy  
11 Families Program (Part 6.2 (commencing with Section 12693) of  
12 Division 2 of the Insurance Code), or a health care service plan  
13 contract offered to a federally eligible defined individual under  
14 Article 4.6 (commencing with Section 1366.35).

15 (2) A local initiative, as defined in subdivision (v) of Section  
16 53810 of Title 22 of the California Code of Regulations, that is  
17 awarded a contract by the State Department of Health Care Services  
18 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
19 California Code of Regulations, shall not be subject to this section  
20 unless the plan offers coverage in the individual market to persons  
21 not covered by Medi-Cal or the Healthy Families Program.

22 (b) (1) A health care service plan that declines to offer coverage  
23 or denies enrollment for an individual or his or her dependents  
24 applying for individual coverage or that offers individual coverage  
25 at a rate that is higher than the standard rate, shall, at the time of  
26 the denial or offer of coverage, provide the individual applicant

1 with the specific reason or reasons for the decision in writing, in  
2 clear, easily understandable language.

3 (2) No change in the premium rate or coverage for an individual  
4 plan contract shall become effective unless the plan has delivered  
5 a written notice of the change at least ~~30~~ 180 days prior to the  
6 effective date of the contract renewal or the date on which the rate  
7 or coverage changes. A notice of an increase in the premium rate  
8 shall include the reasons for the rate increase.

9 (3) The written notice required pursuant to paragraph (2) shall  
10 be delivered to the individual contractholder at his or her last  
11 address known to the plan, at least ~~30~~ 180 days prior to the effective  
12 date of the change. The notice shall state in italics either the actual  
13 dollar amount of the premium rate increase or the specific  
14 percentage by which the current premium will be increased. The  
15 notice shall describe in plain, understandable English any changes  
16 in the plan design or any changes in benefits, including a reduction  
17 in benefits or changes to waivers, exclusions, or conditions, and  
18 highlight this information by printing it in italics. The notice shall  
19 specify in a minimum of 10-point bold typeface, the reason for a  
20 premium rate change or a change to the plan design or benefits.

21 (4) If a plan rejects an applicant or the dependents of an  
22 applicant for coverage or offers individual coverage at a rate that  
23 is higher than the standard rate, the plan shall inform the applicant  
24 about the state's high-risk health insurance pool, the California  
25 Major Risk Medical Insurance Program (Part 6.5 (commencing  
26 with Section 12700) of Division 2 of the Insurance Code). The  
27 information provided to the applicant by the plan shall specifically  
28 include the program's toll-free telephone number and its Internet  
29 Web site address. The requirement to notify applicants of the  
30 availability of the California Major Risk Medical Insurance  
31 Program shall not apply when a health plan rejects an applicant  
32 for Medicare supplement coverage.

33 (c) A notice provided pursuant to this section is a private and  
34 confidential communication and at the time of application, the  
35 plan shall give the individual applicant the opportunity to designate  
36 the address for receipt of the written notice in order to protect the  
37 confidentiality of any personal or privileged information.

38 SEC. 2. Section 1389.26 is added to the Health and Safety  
39 Code, to read:

1 1389.26. (a) (1) This section shall apply only to a full service  
2 health care service plan offering large group health plan contracts  
3 in California and shall not apply to a specialized health care service  
4 plan, a health care service plan contract in the Medi-Cal program  
5 (Chapter 7 (commencing with Section 14000) of Part 3 of Division  
6 9 of the Welfare and Institutions Code), a health care service plan  
7 conversion contract offered pursuant to Section 1373.6, a health  
8 care service plan contract in the Healthy Families Program (Part  
9 6.2 (commencing with Section 12693) of Division 2 of the  
10 Insurance Code), or a health care service plan contract offered to  
11 a federally eligible defined individual under Article 4.6  
12 (commencing with Section 1366.35).

13 (2) A local initiative, as defined in subdivision (v) of Section  
14 53810 of Title 22 of the California Code of Regulations, that is  
15 awarded a contract by the State Department of Health Care Services  
16 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
17 California Code of Regulations, shall not be subject to this section  
18 unless the plan offers large group health plan contracts to persons  
19 not covered by Medi-Cal or the Healthy Families Program.

20 (b) A health care service plan that declines to offer coverage to  
21 or denies enrollment of a large group or that offers large group  
22 coverage at a rate that is higher than the standard rate, shall, at the  
23 time of the denial or offer of coverage, provide the group applicant  
24 with the specific reason or reasons for the decision in writing, in  
25 clear, easily understandable language.

26 (c) A notice provided pursuant to this section is a private and  
27 confidential communication, and at the time of application, the  
28 plan shall give the group applicant the opportunity to designate  
29 the address for receipt of the written notice in order to protect the  
30 confidentiality of any personal or privileged information.

31 (d) For purposes of this subdivision, “large group health plan  
32 contract” or “large group coverage” means a group health care  
33 service plan contract other than a contract issued to a small  
34 employer, as defined in Section 1357.

35 SEC. 3. Section 1389.4 of the Health and Safety Code is  
36 amended to read:

37 1389.4. (a) A full service health care service plan that issues,  
38 renews, or amends individual health plan contracts shall be subject  
39 to this section.

1 (b) A health care service plan subject to this section shall have  
 2 written policies, procedures, or underwriting guidelines establishing  
 3 the criteria and process whereby the plan makes its decision to  
 4 provide or to deny coverage to individuals applying for coverage  
 5 and sets the rate for that coverage. These guidelines, policies, or  
 6 procedures shall assure that the plan rating and underwriting criteria  
 7 comply with Sections 1365.5 and 1389.1 and all other applicable  
 8 provisions of state and federal law.

9 (c) (1) On or before June 1, 2006, and annually thereafter, every  
 10 health care service plan shall file with the department a general  
 11 description of the criteria, policies, procedures, or guidelines the  
 12 plan uses for rating and underwriting decisions related to individual  
 13 health plan contracts, which means automatic declinable health  
 14 conditions, health conditions that may lead to a coverage decline,  
 15 height and weight standards, health history, health care utilization,  
 16 lifestyle, or behavior that might result in a decline for coverage or  
 17 severely limit the plan products for which they would be eligible.  
 18 A plan may comply with this paragraph by submitting to the  
 19 department underwriting materials or resource guides provided to  
 20 plan solicitors or solicitor firms, provided that those materials  
 21 include the information required to be submitted by this section.

22 (2) Commencing January 1, 2011, a plan shall include all of the  
 23 following in the annual filing required under paragraph (1):

24 (A) The number and proportion of applicants denied individual  
 25 coverage during the preceding year ~~and the reasons for those~~  
 26 ~~denials, including the age, gender, race or ethnicity, occupation,~~  
 27 ~~and geographic region of the applicants denied.~~

28 (B) *The reasons for the denial of coverage by the demographic*  
 29 *characteristics in subparagraph (A).*

30 ~~(B)~~

31 (C) The standards, processes, and criteria used by the plan for  
 32 *determining and adjusting premiums applicable to individual plan*  
 33 *contracts based on health status or any other risk factor, including*  
 34 *the actuarial basis for determining premiums for individual plan*  
 35 *contracts.*

36 ~~(C)~~

37 (D) (i) The number and proportion of individual plan contract  
 38 enrollees who paid a premium rate ~~other than that was higher~~ than the  
 39 standard rate and the reasons for ~~that nonstandard rate. the higher~~  
 40 *rate as well as the number and proportion of individual plan*

1 *contract enrollees who paid a premium rate that was lower than*  
2 *the standard rate and the reasons for the lower rate.*

3 *(ii) Demographic information on the number and proportion*  
4 *of individual plan contract enrollees charged a higher rate than*  
5 *the standard rate, including age, gender, occupation, race or*  
6 *ethnicity, and geographic location.*

7 *(iii) Demographic information on the number and proportion*  
8 *of individual plan contract enrollees charged a lower rate than*  
9 *the standard rate, including age, gender, occupation, race or*  
10 *ethnicity, and geographic location.*

11 (d) The department shall disclose the information obtained  
12 pursuant to subdivision (c) to the Managed Risk Medical Insurance  
13 Board and the relevant policy and budget committees of the  
14 Legislature. The department shall also disclose this information  
15 to the public by posting the information on its Internet Web site  
16 in a manner accessible and understandable to consumers. The  
17 information disclosed pursuant to this subdivision shall be company  
18 specific.

19 (e) ~~Commencing September 1, 2006, in~~ *In* addition to the  
20 disclosure required under subdivision (d), the director shall post  
21 on the department's Internet Web site, in a manner accessible and  
22 understandable to consumers, general, noncompany specific  
23 information about rating and underwriting criteria and practices  
24 in the individual market and information about the Major Risk  
25 Medical Insurance Program. The director shall develop the  
26 information for the *Internet* Web site in consultation with the  
27 Department of Insurance to enhance the consistency of information  
28 provided to consumers. Information about individual health  
29 coverage shall also include the following notification:

30 "Please examine your options carefully before declining group  
31 coverage or continuation coverage, such as COBRA, that may be  
32 available to you. You should be aware that companies selling  
33 individual health insurance typically require a review of your  
34 medical history that could result in a higher premium or you could  
35 be denied coverage entirely."

36 (f) This section shall not apply to a closed block of business, as  
37 defined in Section 1367.15.

38 SEC. 4. Section 1389.45 is added to the Health and Safety  
39 Code, to read:

1 1389.45. (a) A full service health care service plan that issues,  
2 renews, or amends large group health plan contracts shall be subject  
3 to this section.

4 (b) On or before June 1, 2011, and annually thereafter, a plan  
5 shall disclose to the department all of the following:

6 (1) The standards, processes, and criteria used by the plan to  
7 deny issuance of a large group plan contract.

8 (2) The number and proportion of groups denied issuance of a  
9 large group plan contract during the preceding year and the reasons  
10 for those denials.

11 (3) The standards, processes, and criteria used by the plan for  
12 adjusting premiums applicable to large group plan contracts based  
13 on health status or any other risk factor, *including the actuarial*  
14 *basis for the rate.*

15 (4) The number and proportion of large groups that paid a  
16 premium rate ~~other~~ *higher* than the standard rate and the reasons  
17 for that ~~nonstandard~~ *higher* rate.

18 (5) *The number and proportion of large groups that paid a*  
19 *premium rate lower than the standard rate and the reasons for*  
20 *that lower rate.*

21 (c) The department shall disclose the information obtained  
22 pursuant to subdivision (b) to the Managed Risk Medical Insurance  
23 Board and the relevant policy and budget committees of the  
24 Legislature. The department shall also disclose this information  
25 to the public by posting the information on its Internet Web site  
26 in a manner accessible and understandable to consumers. The  
27 information disclosed pursuant to this section shall be company  
28 specific.

29 (d) For purposes of this subdivision, “large group health plan  
30 contract” means a group health care service plan contract other  
31 than a contract issued to a small employer as defined in Section  
32 1357.

33 (e) This section shall not apply to a closed block of business,  
34 as defined in Section 1367.15.

35 SEC. 5. Section 10113.9 of the Insurance Code is amended to  
36 read:

37 10113.9. (a) This section shall not apply to short-term limited  
38 duration health insurance, vision-only, dental-only, or  
39 ~~Champus-supplement~~ *CHAMPUS-supplement* insurance, or to  
40 hospital indemnity, hospital-only, accident-only, or specified



1 disease insurance that does not pay benefits on a fixed benefit,  
2 cash payment only basis.

3 (b) (1) A health insurer that declines to offer coverage or denies  
4 enrollment for an individual or his or her dependents applying for  
5 individual coverage or that offers individual coverage at a rate that  
6 is higher than the standard rate shall, at the time of the denial or  
7 offer of coverage, provide the individual applicant with the specific  
8 reason or reasons for the decision in writing, in clear, easily  
9 understandable language.

10 (2) No change in the premium rate or coverage for an individual  
11 health insurance policy shall become effective unless the insurer  
12 has delivered a written notice of the change at least ~~30~~ 180 days  
13 prior to the effective date of the policy renewal or the date on  
14 which the rate or coverage changes. A notice of an increase in the  
15 premium rate shall include the reasons for the rate increase.

16 (3) The written notice required pursuant to paragraph (2) shall  
17 be delivered to the individual policyholder at his or her last address  
18 known to the insurer, at least ~~30~~ 180 days prior to the effective  
19 date of the change. The notice shall state in italics either the actual  
20 dollar amount of the premium increase or the specific percentage  
21 by which the current premium will be increased. The notice shall  
22 describe in plain, understandable English any changes in the policy  
23 or any changes in benefits, including a reduction in benefits or  
24 changes to waivers, exclusions, or conditions, and highlight this  
25 information by printing it in italics. The notice shall specify in a  
26 minimum of 10-point bold typeface, the reason for a premium rate  
27 change or a change in coverage or benefits.

28 (4) If an insurer rejects an applicant or the dependents of an  
29 applicant for coverage or offers individual coverage at a rate that  
30 is higher than the standard rate, the insurer shall inform the  
31 applicant about the state's high-risk health insurance pool, the  
32 California Major Risk Medical Insurance Program (Part 6.5  
33 (commencing with Section ~~12700~~ 12700)). The information  
34 provided to the applicant by the insurer shall specifically include  
35 the program's toll-free telephone number and its Internet Web site  
36 address. The requirement to notify applicants of the availability  
37 of the California Major Risk Medical Insurance Program shall not  
38 apply when a health plan rejects an applicant for Medicare  
39 supplement coverage.

1 (c) A notice provided pursuant to this section is a private and  
2 confidential communication and, at the time of application, the  
3 insurer shall give the individual applicant the opportunity to  
4 designate the address for receipt of the written notice in order to  
5 protect the confidentiality of any personal or privileged  
6 information.

7 SEC. 6. Section 10113.91 is added to the Insurance Code, to  
8 read:

9 10113.91. (a) This section shall apply only to a health insurer  
10 offering large group health insurance policies in California. This  
11 section shall not apply to short-term limited duration health  
12 insurance, vision-only, dental-only, or ~~Champus-supplement~~  
13 *CHAMPUS-supplement* insurance, or to hospital indemnity,  
14 hospital-only, accident-only, or specified disease insurance that  
15 does not pay benefits on a fixed benefit, cash payment only basis.

16 (b) A health insurer that declines to offer coverage to or denies  
17 enrollment of a large group or that offers large group coverage at  
18 a rate that is higher than the standard rate shall, at the time of the  
19 denial or offer of coverage, provide the group applicant with the  
20 specific reason or reasons for the decision in writing, in clear,  
21 easily understandable language.

22 (c) A notice provided pursuant to this section is a private and  
23 confidential communication and at the time of application, the  
24 insurer shall give the group applicant the opportunity to designate  
25 the address for receipt of the written notice in order to protect the  
26 confidentiality of any personal or privileged information.

27 (d) For purposes of this subdivision, “large group policy” or  
28 “large group coverage” means a group health insurance policy  
29 other than a policy issued to a small employer, as defined in Section  
30 10700.

31 SEC. 7. Section 10113.95 of the Insurance Code is amended  
32 to read:

33 10113.95. (a) A health insurer that issues, renews, or amends  
34 individual health insurance policies shall be subject to this section.

35 (b) An insurer subject to this section shall have written policies,  
36 procedures, or underwriting guidelines establishing the criteria  
37 and process whereby the insurer makes its decision to provide or  
38 to deny coverage to individuals applying for coverage and sets the  
39 rate for that coverage. These guidelines, policies, or procedures  
40 shall assure that the plan rating and underwriting criteria comply

1 with Sections 10140 and 10291.5 and all other applicable  
2 provisions.

3 (c) (1) On or before June 1, 2006, and annually thereafter, every  
4 insurer shall file with the commissioner a general description of  
5 the criteria, policies, procedures, or guidelines that the insurer uses  
6 for rating and underwriting decisions related to individual health  
7 insurance policies, which means automatic declinable health  
8 conditions, health conditions that may lead to a coverage decline,  
9 height and weight standards, health history, health care utilization,  
10 lifestyle, or behavior that might result in a decline for coverage or  
11 severely limit the health insurance products for which they would  
12 be eligible. An insurer may comply with this paragraph by  
13 submitting to the department underwriting materials or resource  
14 guides provided to agents and brokers, provided that those materials  
15 include the information required to be submitted by this section.

16 (2) Commencing January 1, 2011, an insurer shall include all  
17 of the following in the annual filing required under paragraph (1):

18 (A) The number and proportion of applicants denied individual  
19 coverage during the preceding year ~~and the reasons for those~~  
20 ~~denials, including the age, gender, race or ethnicity, occupation,~~  
21 ~~and geographic region of the applicants denied.~~

22 (B) *The reasons for the denial of coverage by the demographic*  
23 *characteristics in subparagraph (A).*

24 ~~(B)~~

25 (C) The standards, processes, and criteria used by the insurer  
26 for *determining and* adjusting premiums applicable to individual  
27 policies based on health status or any other risk factor, *including*  
28 *the actuarial basis for determining premiums for individual*  
29 *policies.*

30 ~~(C)~~

31 (D) (i) The number and proportion of insureds under an  
32 individual policy who paid a premium rate ~~other~~ *that was higher*  
33 *than the standard rate and the reasons for that nonstandard rate.*  
34 *the higher rate as well as the number and proportion of individual*  
35 *policyholders who paid a premium rate that was lower than the*  
36 *standard rate and the reasons for the lower rate.*

37 (ii) *Demographic information on the number and proportion*  
38 *of individual policyholders charged a higher rate than the standard*  
39 *rate, including age, gender, occupation, race or ethnicity, and*  
40 *geographic location.*

1 (iii) *Demographic information on the number and proportion*  
2 *of individual policyholders charged a lower rate than the standard*  
3 *rate, including age, gender, occupation, race or ethnicity, and*  
4 *geographic location.*

5 (d) The commissioner shall disclose the information obtained  
6 pursuant to subdivision (c) to the Managed Risk Medical Insurance  
7 Board and the relevant policy and budget committees of the  
8 Legislature. The department shall also disclose this information  
9 to the public by posting the information on its Internet Web site  
10 in a manner accessible and understandable to consumers. The  
11 information disclosed pursuant to this subdivision shall be company  
12 specific.

13 (e) ~~Commencing September 1, 2006, in~~ *In* addition to the  
14 disclosure required under subdivision (d), the commissioner shall  
15 post on the department's Internet Web site, in a manner accessible  
16 and understandable to consumers, general, noncompany specific  
17 information about rating and underwriting criteria and practices  
18 in the individual market and information about the Major Risk  
19 Medical Insurance Program. The commissioner shall develop the  
20 information for the *Internet* Web site in consultation with the  
21 Department of Managed Health Care to enhance the consistency  
22 of information provided to consumers. Information about individual  
23 health insurance shall also include the following notification:

24 "Please examine your options carefully before declining group  
25 coverage or continuation coverage, such as COBRA, that may be  
26 available to you. You should be aware that companies selling  
27 individual health insurance typically require a review of your  
28 medical history that could result in a higher premium or you could  
29 be denied coverage entirely."

30 (f) This section shall not apply to a closed block of business, as  
31 defined in Section 10176.10.

32 SEC. 8. Section 10113.96 is added to the Insurance Code, to  
33 read:

34 10113.96. (a) A health insurer that issues, renews, or amends  
35 large group health insurance policies shall be subject to this section.

36 (b) On or before June 1, 2011, and annually thereafter, an insurer  
37 shall disclose to the commissioner all of the following:

38 (1) The standards, processes, and criteria used by the insurer to  
39 deny issuance of a large group health insurance policy.

1 (2) The number and proportion of groups denied issuance of a  
2 large group health insurance policy during the preceding year and  
3 the reasons for those denials.

4 (3) The standards, processes, and criteria used by the insurer  
5 for adjusting premiums applicable to large group health insurance  
6 policies based on health status or any other risk factor, *including*  
7 *the actuarial basis for the rate.*

8 (4) The number and proportion of large groups that paid a  
9 premium rate ~~other~~ *higher* than the standard rate and the reasons  
10 for that ~~nonstandard~~ *higher* rate.

11 (5) *The number and proportion of large groups that paid a*  
12 *premium rate lower than the standard rate and the reasons for*  
13 *that lower rate.*

14 (c) The commissioner shall disclose the information obtained  
15 pursuant to subdivision (b) to the Managed Risk Medical Insurance  
16 Board and the relevant policy and budget committees of the  
17 Legislature. The commissioner shall also disclose this information  
18 to the public by posting the information on the department's  
19 Internet Web site in a manner accessible and understandable to  
20 consumers. The information disclosed pursuant to this section shall  
21 be company specific.

22 (d) For purposes of this subdivision, "large group health  
23 insurance policy" means a group health insurance policy other  
24 than a policy issued to a small employer, as defined in Section  
25 10700.

26 (e) This section shall not apply to a closed block of business,  
27 as defined in Section 10176.10.

28 SEC. 9. No reimbursement is required by this act pursuant to  
29 Section 6 of Article XIII B of the California Constitution because  
30 the only costs that may be incurred by a local agency or school  
31 district will be incurred because this act creates a new crime or  
32 infraction, eliminates a crime or infraction, or changes the penalty  
33 for a crime or infraction, within the meaning of Section 17556 of  
34 the Government Code, or changes the definition of a crime within  
35 the meaning of Section 6 of Article XIII B of the California  
36 Constitution.

- 1 \_\_\_\_\_
- 2 **CORRECTIONS:**
- 3 **Text—Pages 6, 7, 11 and 12.**
- 4 \_\_\_\_\_

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