HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 3. Licensing and Fees [1349 - 1356.3] *(Article 3 added by Stats. 1975, Ch. 941.)*

1349. It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder. A person licensed pursuant to this chapter need not be licensed pursuant to the Insurance Code to operate a health care service plan or specialized health care service plan unless the plan is operated by an insurer, in which case the insurer shall also be licensed by the Insurance Commissioner.

(Amended by Stats. 1999, Ch. 525, Sec. 49. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1349.1. A health care service plan which satisfies both of the following criteria is exempt from Section 1349:

(a) Provides only emergency ambulance services or advanced life support services, as defined by Section 1797.52, or both.

(b) Is operated by the State of California, any city, county, city and county, public district, or public authority.

(Added by Stats. 1986, Ch. 502, Sec. 1.)

1349.2. (a) A health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies all of the following criteria is exempt from this chapter:

(1) Provides services or reimbursement only to employees, retirees, and the dependents of those employees and retirees, of any participating city, county, city and county, public entity, or political subdivision, but not to the general public.

(2) Provides funding for the program.

(3) Provides that providers are reimbursed solely on a fee-for-service basis, so that providers are not at risk in contracting arrangements.

(4) Complies with Section 1378 and, to the extent that a plan contracts directly with providers for health care services, complies with Section 1379.

(5) Does not reduce or change current benefits except in accordance with collective bargaining agreements, or as otherwise authorized by the governing body in the case of unrepresented employees, and provides, pays for, or reimburses at least part of the cost of all basic health care services as defined in subdivision (b) of Section 1345. Plans covering only a single specialized health care service, including dental, vision, or mental health services, shall not be required to cover all basic health care services.

(6) Refrains from any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code, and notifies enrollees of their right to file complaints with the director regarding any violation of this exemption.

(7) Maintains a fiscally sound operation and makes adequate provision against the risk of insolvency so that enrollees are not at risk, individually or collectively, as evidenced by audited financial statements submitted to the director as of the end of the plan's fiscal year, within 180 days after the close of that fiscal year. The financial statements shall be accompanied by a report, certificate, or opinion of an independent certified public accountant. The financial statements shall be prepared in accordance with

generally accepted accounting principles. The audit shall be conducted in accordance with generally accepted auditing standards. However, audits of public entities or political subdivisions shall be conducted in accordance with governmental auditing standards. Upon request, the governing body of the plan shall provide copies thereof, without charge, to any enrollee or recognized and participating employee organization.

(8) Submits with the annual financial statements required under paragraph (7), a declaration, which shall conform to Section 2015.5 of the Code of Civil Procedure, executed by a plan official authorized by the governing body of the plan, that the plan complies with this subdivision.

(b) The director's responsibilities under this section shall be limited to enforcing compliance with this section. Nothing in this section shall impair or impede the director's enforcement authority or the remedies available under this chapter, including, but not limited to, the termination of the plan's exemption under this section.

(c) A public joint labor management trust is a trust maintained by one or more participating cities, counties, cities and counties, public entities, or political subdivisions that appoint management representatives, and one or more recognized and participating employee organizations representing the employees of one or more of the cities, counties, cities and counties, public entities, or political subdivisions that appoint labor representatives, in which the management representatives and the labor representatives have equal voting power in the operation of the trust.

(d) A public joint labor management trust shall not be deemed to provide services or reimbursement to the general public if, in addition to providing services or reimbursement to the persons described in paragraph (1) of subdivision (a), it provides services or reimbursement only to employees, retirees, and dependents of those employees and retirees, of the recognized and participating employee organizations or of the trust.

(e) Nothing in this section shall be construed to prohibit a recognized and participating employee organization from filing a complaint with the director regarding a violation of this section.

(Amended by Stats. 1999, Ch. 525, Sec. 50. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1350. (a) Consistent with federal law, a sponsor of a prescription drug plan authorized by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) shall hold a valid license as a health care service plan issued by the department or as a life and disability insurer by the Department of Insurance.

(b) An entity that is licensed as a health care service plan and that operates a prescription drug plan shall be subject to the provisions of this chapter, unless preempted by federal law.

(Added by Stats. 2005, Ch. 230, Sec. 1. Effective September 6, 2005.)

1351. Each application for licensure as a health care service plan or specialized health care service plan under this chapter shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. This application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall set forth or be accompanied by each and all of the following:

(a) The basic organizational documents of the applicant; such as, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5-percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(d) A copy of any contract made, or to be made, between the applicant and any provider of health care services, or persons listed in subdivision (c), or any other person or organization agreeing to perform an administrative function or service for the plan. The director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the director, except that such payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The plan shall also submit the name and address of each physician employed by or contracting with the plan, together with his or her license number.

(e) A statement describing the plan, its method of providing for health care services and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the plan including the number of full-time and part-time primary physicians, the number of full-time and part-time and specialties of all nonprimary physicians; the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which

health care services will be provided. For purposes of this subdivision, primary physicians include general and family practitioners, internists, pediatricians, obstetricians, and gynecologists.

(f) A copy of the forms of evidence of coverage and of the disclosure forms or material which are to be issued to subscribers or enrollees of the plan.

(g) A copy of the form of the individual contract which is to be issued to individual subscribers and the form of group contract which is to be issued to any employers, unions, trustees, or other organizations.

(h) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with such requirements as may be established by regulation of the director.

(i) A description of the proposed method of marketing the plan and a copy of any contract made with any person to solicit on behalf of the plan or a copy of the form of agreement used and a list of the contracting parties.

(j) A power of attorney duly executed by any applicant, not domiciled in this state, appointing the director the true and lawful attorney in fact of such applicant in this state for the purposes of service of all lawful process in any legal action or proceeding against the plan on a cause of action arising in this state.

(k) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the plan and the location of any other plan facilities where required by the director.

(l) A description of enrollee-subscriber grievance procedures to be utilized as required by this chapter, and a copy of the form specified by subdivision (c) of Section 1368.

(m) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this chapter.

(n) A description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan.

(o) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

(p) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the director.

(q) If required by the director by rule pursuant to Section 1376, a fidelity bond or a surety bond in the amount prescribed.

(r) Evidence of adequate workmen's compensation insurance coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of a plan against the plan.

(s) All relevant information known to the applicant concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or other affiliate, has any of the following:

(1) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits in this state or any other state.

(2) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits authorized for reimbursement under the federal Medicare or Medicaid Program.

(3) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging for the provision of, health care services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer in this state or any other state.

(t) Such other information as the director may reasonably require.

(Amended by Stats. 2006, Ch. 758, Sec. 2. Effective January 1, 2007.)

1351.1. In addition to the requirements of Section 1351 and upon request of the director, each application shall be accompanied by authorization for disclosure to the director of financial records of each health care service plan or specialized health care service plan licensed under this chapter pursuant to Section 7473 of the Government Code. For the purpose of this chapter, the authorization for disclosure shall also include the financial records of any association, partnership or corporation controlling, controlled by or otherwise affiliated with a health care service plan or specialized health care service plan.

(Amended by Stats. 1999, Ch. 525, Sec. 52. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1351.2. (a) If a prepaid health plan operating lawfully under the laws of Mexico elects to operate a health care service plan in this state, the prepaid health plan shall apply for licensure as a health care service plan under this chapter by filing an application for licensure in the form prescribed by the department and verified by an authorized representative of the applicant. The prepaid health plan shall be subject to the provisions of this chapter, and the rules adopted by the director thereunder, as determined by the director to be applicable. The application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall demonstrate compliance with the following requirements:

(1) The prepaid health plan is constituted and operating lawfully under the laws of Mexico and, if required by Mexican law, is authorized as an Insurance Institution Specializing in Health by the Mexican Insurance Commission. If the Mexican Insurance Commission determines that the prepaid health plan is not required to be authorized as an Insurance Institution Specializing in Health under the laws of Mexico, the applicant shall obtain written verification from the Mexican Insurance Commission stating that the applicant is not required to be authorized as an Insurance Institution Specializing in Health in Mexico. A Mexican prepaid health plan that is not required to be an Insurance Institution Specializing in Health shall obtain written verification from the Mexican Ministry of Health that the prepaid health plan and its provider network are operating in full compliance of Mexican law.

(2) The prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of Mexican nationals legally employed in the County of San Diego or the County of Imperial, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The prepaid health plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars ($1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars ($1,000,000), the prepaid health plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The prepaid health plan shall also maintain a fidelity bond and a surety bond as required by Section 1376 and the rules of the director.

(8) The prepaid health plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the director in the form and at the time and place requested by the director. Books and records shall be made available to the director no later than 24 hours from the date of the request.

(9) The prepaid health plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. The prepaid health plan shall agree to notify the director, immediately and in no case later than one business day, if it is subject to any investigation, examination, or administrative or legal action relating to the prepaid health plan or the operations of the prepaid health plan initiated by the government of Mexico or the government of any state of Mexico against the prepaid health plan or any officer, director, security holder, or contractor owning 10 percent or more of the securities of the prepaid health plan. The prepaid health plan shall agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States shall apply.

(10) The prepaid health plan agrees that disputes arising from the group contracts involving group contractholders and providers of health care services in the United States shall be subject to the jurisdiction of the courts of this state and the United States.

(11) The prepaid health plan shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act for health care services set forth in paragraph (4). For health care services that are to be provided or delivered wholly in Mexico, the prepaid health plan may employ or designate a medical director operating under the laws of Mexico.

(b) The prepaid health plan shall pay the application processing fee and other fees and assessments set forth in Section 1356. The director, by order, may designate provisions of this chapter and rules adopted thereunder that need not be applied to a prepaid health plan licensed under the laws of Mexico when consistent with the intent and purpose of this chapter, and in the public interest.

(c) If the plan ceases to operate legally in Mexico, the director shall immediately deliver written notice to the health care service plan that it is not in compliance with the provisions of this section. If this occurs, a health care service plan shall do all of the following:

(1) Provide the director with written proof that the prepaid health plan has complied with the laws of Mexico not later than 45 days after the date the written notice is received by the health care service plan.

(2) If, by the 45th day, the health care service plan is unable to provide written confirmation that it is in full compliance with Mexican law, the director shall notify the health care service plan in writing that it is prohibited from accepting any new enrollees or subscribers. The health care service plan shall be given an additional 180 days to comply with Mexican law or to become a licensed health care service plan.

(3) If, at the end of the 180-day notice period in paragraph (2), the health care service plan has not complied with the laws of Mexico or California, the director shall issue an order that the health care service plan cease and desist operations in California.

(Amended (as amended by Stats. 2004, Ch. 491, Sec. 1) by Stats. 2007, Ch. 196, Sec. 1. Effective January 1, 2008.)

1351.3. On and after January 1, 2007, the department, in considering an application for an initial license for any entity under this chapter, shall consider any information provided concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate has any history of noncompliance, as described in subdivision (s) of Section 1351, and any other relevant information concerning misconduct.

(Added by Stats. 2006, Ch. 758, Sec. 3. Effective January 1, 2007.)

1352. (a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code.

(b) Prior to a material modification of its plan or operations, a plan shall give notice thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approve, disapprove, suspend, or postpone the effectiveness of the change, subject to Section 1354.

(c) A plan shall, within five days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

(d) The fee for filing a notice of material modification pursuant to subdivision (b) shall be the actual cost to the director of processing the notice, including overhead, but shall not exceed seven hundred fifty dollars ($750).

(Amended by Stats. 2007, Ch. 577, Sec. 11. Effective October 13, 2007.)

1352.1. (a) Except as provided in subdivision (b), no plan shall enter into any new or modified plan contract or publish or distribute, or allow to be published or distributed on its behalf, any disclosure form or evidence of coverage, unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the plan contract, disclosure form, or evidence of coverage, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within at least 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (d), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months and which has had group contracts in effect at all times during that period may enter a new or modified group contract or may publish or distribute, or allow to be published or distributed on its behalf, any group disclosure form or evidence of coverage without having filed the same for the director’s prior approval, if the plan and the materials comply with each of the following conditions:

(1) The contract, disclosure form, or evidence of coverage, or any material provision thereof, has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the contract, disclosure form, and evidence of coverage do not violate any requirements of this chapter or the rules thereunder.

(2) The plan files the contract and any related disclosure form and evidence of coverage with the director not later than 10 business days after entering the contract, or within any additional period as the director by rule or order may provide.

(3) If the person or group entering into the contract with the plan is not an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), the person or group is not organized solely or principally for the purpose of providing health benefits to members of the group.

(c) Effective January 1, 2025, a plan shall utilize the standard templates developed by the department pursuant to Section 1363 for any disclosure form or evidence of coverage published or distributed. This subdivision shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(d) The director by order may require a plan which has entered any group contract or published or distributed, or allowed to be published or distributed on its behalf, any disclosure form or evidence of coverage in violation of this chapter or the rules thereunder to comply with subdivision (a) prior to entering group contracts, or a specified class of group contracts, and prior to publishing or distributing, or allowing to be published or distributed on its behalf, related disclosure forms and evidences of coverage. An order issued pursuant to this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the contracts, disclosure forms, or evidences of coverage submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(e) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

(Amended by Stats. 2023, Ch. 42, Sec. 12. (AB 118) Effective July 10, 2023.)

1353. The director shall issue a license to any person filing an application pursuant to this article, if the director, upon due consideration of the application and of the information obtained in any investigation, including, if necessary, an onsite inspection, determines that the applicant has satisfied the provisions of this chapter and that, in the judgment of the director, a disciplinary action pursuant to Section 1386 would not be warranted against such applicant. Otherwise, the director shall deny the application.

(Amended by Stats. 1999, Ch. 525, Sec. 56. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1354. Upon denial of application for licensure, or the issuance of an order pursuant to Section 1352 disapproving, suspending, or postponing a material modification, the director shall notify the applicant in writing, stating the reason for the denial and that the applicant has the right to a hearing if the applicant makes written request within 30 days after the date of mailing of the notice of denial. Service of the notice required by this subdivision may be made by certified mail addressed to the applicant at the latest address filed by the applicant in writing with the department.

(Amended by Stats. 1999, Ch. 525, Sec. 57. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1355. Every plan's license issued under this chapter shall remain in effect until revoked or suspended by the director, except that every transitional license shall expire on September 30, 1978, unless such expiration date is extended by the director.

(Amended by Stats. 1999, Ch. 525, Sec. 58. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant prior to receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b) (1) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances, and complaints including maintaining a toll-free telephone number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(2) The amount paid by each plan shall be ten thousand dollars ($10,000) plus an amount up to, but not exceeding, an amount computed in accordance with paragraph (3).

(3) (A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048), for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(f) On and after January 1, 2009, no refunds or reductions of the amounts assessed shall be allowed if any miscalculated assessment is based on a plan's overestimate of enrollment.

(Amended by Stats. 2008, Ch. 607, Sec. 2. Effective September 30, 2008.)

1356.1. Notwithstanding subdivision (f) of Section 1356, as amended by Section 2.5 of Chapter 722 of the Statutes of 1991, and subdivision (d) of Section 1356, as amended by Section 3 of Chapter 722 of the Statutes of 1991, if the director determines that the charges and assessments set forth in this chapter for any year are in excess of the amount necessary, or are insufficient, to meet the expenses of administration of this chapter, for that year, the assessments and charges for the following year shall be adjusted on a pro rata basis in accordance with the percentage of the excess or insufficiency as related to the actual charges and assessments for the year for which the excess or insufficiency occurred, in order to recover the actual costs of administration.

(Amended by Stats. 1999, Ch. 525, Sec. 60. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1356.2. The director, by notice to all licensed health care service plans on or before October 15, 2010, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses of the department as set forth in subdivision (b) of Section 1341.4 and Section 1356 for the 2010–11 fiscal year. The assessment paid pursuant to this section shall be separate and independent of the assessment imposed pursuant to subdivision (b) of Section 1356 and shall not be aggregated with the assessment imposed pursuant to subdivision (b) of Section 1356 for the purposes of limitation or otherwise. The assessment paid pursuant to this section shall not be subject to the limitations imposed on assessments pursuant to Section 1356.1. In imposing an assessment pursuant to this section, the director shall levy on each health care service plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b) of Section 1356. The assessments imposed pursuant to this section shall be paid in full by December 1, 2010. On and after July 1, 2011, and until August 31, 2015, the director may raise the assessment limit described in subdivision (b) of Section 1356 to incorporate the annual expenditure levels set forth in this section.

(Added by Stats. 2010, Ch. 717, Sec. 11. (SB 853) Effective October 19, 2010.)

1356.3. (a) For the 2025–26 to 2026–27 fiscal years, inclusive, a health care service plan licensed by the department shall be assessed an annual fee in an amount determined by the department, in consultation with the Department of Health Care Access and Information. The annual fee shall be limited to the amount necessary to fund the actual and reasonably necessary expenses of the department to implement Article 6.1 (commencing with Section 1385.001) and the actual and reasonably necessary expenses of the

Department of Health Care Access and Information pertaining to data reporting by pharmacy benefit managers, including that portion of the Health Care Payments Data Program established by Section 127671.1 that concerns pharmacy benefit managers.

(b) The fees received pursuant to this section shall be transferred from the Managed Care Fund to the Pharmacy Benefit Manager Fund established by Section 1385.0017 and disbursed pursuant to that section, upon appropriation by the Legislature.

(Added by Stats. 2025, Ch. 21, Sec. 7. (AB 116) Effective June 30, 2025.)